STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Norma Martinez,

Petitioner,

14IWCC0031

vs.

NO: 11 WC 33823

Paramount Staffing,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, prospective medical expenses, temporary total disability, causal connection, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0031

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 1 2014

David L. Gore

Michael J. Brennan

Mario Basurto

DLG/gal
O: 1/16/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR
CORRECTED

MARTINEZ, NORMA
Employee/Petitioner

Case# **11WC033823**

14IWCC0031

PARAMOUNT STAFFING
Employer/Respondent

On 5/24/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2553 McHARGUE, JAMES P LAW OFFICE
MATTHEW C JONES
100 W MONROE ST SUITE 1112
CHICAGO, IL 60603

4696 POULOS & DIBENEDETTO LAW PC
JEFFREY TRAVIS
850 W JACKSON BLVD SUITE 300
CHICAGO, IL 60607

STATE OF ILLINOIS)
)SS.
COUNTY OF kane)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION

CORRECTED ARBITRATION DECISION

19(b)

14IWCC0031

Norma Martinez
Employee/Petitioner

v.

Paramount Staffing
Employer/Respondent

Case# 11 WC 33823

Consolidated cases: NA

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros** Arbitrator of the Commission, in the city of **Geneva**, on **September 11, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

14IWCC0031

FINDINGS

On the date of accident, **July 22, 2011**, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,558.80**; the average weekly wage was **$356.90**.

On the date of accident, Petitioner was **40** years of age, single with **0** dependent child.

Respondent has not paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$1,066.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,066.68**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $ 237.93 per week for 54 6/7 weeks, commencing August 25, 2011 through September 11, 2012, as provided in Section 8(b) of the Act.

Medical benefits

Respondent is liable for reasonable and necessary medical services of: Marque Medicos, $23,292.12; Medicos Pain and Surgical, $44,072.40; American Ctr. for Spine and Neurosurgery, $7,000.00; Specialized Radiology, $55.00; Archer Open MRI, $1,617.75; Industrial Pharmacy Mgmt., $528.64; Metro Anesthesia, $4,409.64; Naperville Medical Imaging, $1,931.00, as provided in Section 8(a) of the Act. All amounts to be awarded pursuant to the applicable IWCC Fee Schedule.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

Prospective Medical Care

Respondent shall authorize and pay for the L4-5 to L5-S1 lumbar fusion as recommended by Dr. Robert Erickson pursuant to section 8(a). Dr. Erickson's opinion is adopted as much more persuasive and thorough than the opinion of Dr. Lami. The Arbitrator underscores Dr. Erickson's Px. 6 office visit opinion of 5/11/12 fourth paragraph in total as the concise tipping point opinion. He cited Dr. Lami ignoring the discogram along with the supporting findings of MRI, neurophysiologic studies and clinical examination over a reasonable period of time. His testimony is also adopted per Px.1. Dep Ex.1 shows this accomplished medical author is an associate professor of neurological surgery at the University of Chicago. He is affilicated with the American Center for Spine & Neurosurgery in Libertyville along with two other neurosurgeons.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

OI Signature of Arbitrator

Date 5-21-13

ICArbDec19(b)

MAY 24 2013

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherlie Smith,

Petitioner,

vs.

NO: 11 WC 39449

14IWCC0032

Bridgeview Healthcare,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 15, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0032

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
TJT:yl
o 1/14/14
51

Thomas J. Tyrrell

Kevin W. Lamboth

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

SMITH, SHERLIE
Employee/Petitioner

Case# **11WC039449**

BRIDGEVIEW HEALTHCARE
Employer/Respondent

14IWCC0032

On 2/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0491 SOSTRIN & SOSTRIN PC
NEIL WISHNICK
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

0208 GALLIANI DOELL & COZZI LTD
ROBERT COZZI
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

14IWCC0032

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sherlie Smith
Employee/Petitioner

v.

Bridgeview Helathcare
Employer/Respondent

Case # 11 WC 39449

Consolidated cases: ----

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **May 15, 2012** and **August 20, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

14IWCC0032

FINDINGS

On the date of accident, **January 11, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned an average weekly wage was **$158.00**.

On the date of accident, Petitioner was **55** years of age, *single* with **0** dependent child.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ **615.12** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$615.12**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

- The Arbitrator finds that the petitioner failed to prove that a causal connection exists between her current condition of ill-being and her work accident; therefore, the petitioner's claims for temporary total disability benefits and prospective medical care are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

February 14, 2013
Date

ICArbDec19(b)

FEB 15 2013

Statement of Facts

Petitioner reported an accident to her right shoulder on January 11, 2011 after she tripped over a scale. This is unrebutted and confirmed by Zelma Daniels (p. 88).

Petitioner treated at the company clinic, Concentra Medical Center, on January 12, 2011. She reported pain in the anterior aspect of the right knee and pain in the anterior aspect of her right shoulder. X-rays were taken of Petitioner's right knee and right shoulder; shoulder x-rays were negative for fracture or dislocation. Upon examination, Dr. Garces found the following for Petitioner's right shoulder: "No bruising. No ecchymosis. Shoulder shows no deformity. No tenderness present. Full active Range of Motion, including abduction, forward flexion, extension, adduction, internal and external rotation. Normal rotator cuff motion. Tenderness of the anterior aspect of. Speed negative. Supraspinatus negative. Hawkins impingement negative. Apprehension test negative. Drop test negative." Physician's assessment was knee contusion and shoulder. Ibuprofen and a home exercise program was prescribed. Petitioner was released to return to regular-duty work.

Petitioner testified that she returned to work in pain. She noticed that lifting made the pain worse. Petitioner testified that she told her co-workers about the pain in her right arm and shoulder. (pp. 21-22, 25). Petitioner continued to work and took over-the-counter medication. Eventually, the medication this did not help her pain and she couldn't handle her job (p. 33).

Petitioner testified that she did not seek a doctor for her right shoulder between January 2011 and August 2011 because she had "no insurance." She testified that she found out about workers' compensation and talked to the administrator (p. 33-34). This was three months after the accident (p. 34). She talked with Zelma occasionally and she would get someone to help her lift patients. (p. 38-39).

The medical records show that Petitioner treated at Aunt Martha's Health Center on March 22, 2011. The medical professional listed a history of various medical conditions. No history of right arm or right shoulder pain or of a fall at work was listed. Petitioner voiced no complaints of right arm or right shoulder pain at that time. The medical professional wrote: "Needs refill on her anxiety meds & something for dermatitis. Ø other symptoms or complaints … appears well … good mood …" Upon examination, the medical professional found that her EXTREMITIES (range of motion, arms, legs, gait) were within normal limits. (Px.5)

Respondent transferred Petitioner to the fourth floor on a permanent basis in July 2011. Respondent sent her back to Concentra for right shoulder treatment. Concentra referred her to Dr. Kevin Tu, an orthopedic surgeon. She first saw Dr. Tu on September 28, 2011. Dr. Tu ordered an MRI and later gave Petitioner a cortisone shot. The MRI revealed supraspinatus tendinosis with no evidence of a tear, type II acromion process and moderate AC joint arthropathy. Dr. Tu later prescribed that Petitioner undergo a right shoulder arthroscopic subacromial decompression, possible rotator cuff repair and distal

clavicle excision. Dr. Tu causally related the Petitioner's current condition of ill-being of her right shoulder to her work injury of January 11, 2011. Dr. Tu issued a narrative report. (Px.6) None of Dr. Tu's treating records were offered into evidence.

Petitioner also saw Dr. Gregory P. Nicholson, an orthopedic surgeon. Dr. Nicholson authored a report that is dated October 26, 2011. After taking a history and physical, Dr. Nicholson diagnosed Petitioner with right rotator cuff tendinitis. He found the MRI to be of poor quality. He recommended a cortisone injection and a soft-tissue physical therapy program. He released Petitioner to return to light-duty work. Dr. Nicholson noted that Petitioner has had six months of shoulder pain and opined that Petitioner's shoulder condition was "incurred in the fall." (Px.3)

The Petitioner was seen at the request of the Respondent by orthopedic surgeon, Dr. Kenneth Schiffman, on December 23, 2011. She localized the pain in the trapezial and medial axillary regions. She also complained of radiation of the pain down the arm. His physical examination revealed tenderness in the trapezius muscle; no scapular winging; negative Hawkins sign; full elevation; non-tender AC joint; abduction and internal and external rotation were grade 5. He concluded that her pain was diffuse, not consistent with the diagnosis of rotator cuff pathology and more typical of a cervical radicular problem. He indicated that her subjective complaints are not related to the injury in January of 2011. He found that she did not require any additional medical treatment as a result of the work injury. Specifically, she should not undergo a right shoulder surgical procedure. (Rx.1) Dr. Schiffman issued a supplemental report in which he indicated that he specifically reviewed the note of January 12, 2011, which did not change any of the opinions in his original report. He also indicated that he treats shoulder problems and performs shoulder surgery. (Rx.2)

Zelma Daniels testified that she was employed by the respondent as a LPN and was the Petitioner's supervisor when she worked on the third floor. When the Petitioner fell on January 11, 2011, she heard the noise and went to help the Petitioner. She told Petitioner to fill out an accident report. Ms. Daniels testified that on subsequent occasions, the Petitioner complained of shoulder pain. However, Ms. Daniels could not specify when Petitioner voiced such complaints. Ms. Daniels told her that she would have to go to Aasta James, the Director of Nursing, for any of her complaints or worker's compensation issues.

Ms. Daniels never went to Aasta James herself to advise her that the Petitioner was complaining of shoulder pain. Ms. Daniels is no longer working for the Respondent. In October of 2011, she received two disciplinary warnings regarding job performance issues and resigned for health reasons.

Aasta James testified that Respondent has employed her for nineteen years. For the past four years, she has been the Director of Nursing for the Respondent. Her job duties include staffing, hiring CNA's, LPN's and RN's, and enforcing the implementation of policies and procedures at the facility. She is overall in charge of all CNA's LPN's and

RN's. If an individual under her charge is injured at work, she has the responsibility of handling the situation.

The Respondent has employed the Petitioner as a CNA since 2010. Petitioner was one of the people that Ms. James supervised. The Petitioner worked the 3:00 – 11:00 P.M. shift and Ms. James worked a later shift, but there was a shift overlap of a few hours each day. She would see Petitioner at the facility on a daily basis.

In January of 2011, Aasta James became aware that the Petitioner had hurt herself. She had a conversation with the Petitioner on the day after the accident when she received the incident report. Ms. James sent her for medical treatment at the Concentra facility, a nearby occupational health clinic. After that visit, the Petitioner continued to work her normal job duties from January 12, 2011 through August 30, 2011. According to Ms. James, the Petitioner never complained of any physical problems with her shoulder until August of 2011. Furthermore, Ms. James testified that the Petitioner did not appear to be in any pain while she performed her normal job duties. Ms. James further testified that between January 12, 2011 and August 30, 2011, the Petitioner neither told her that she needed to work light duty because of a problem with her shoulder nor indicated to her that she needed assistance in performing her regular job duties. Prior to August 30, 2011, the Petitioner did not ask for permission to seek medical attention. Towards the end of August of 2011, Ms. James became aware that the Petitioner was having a problem with her shoulder. She instructed the Petitioner to go to the Concentra facility.

On cross-examination of Aasta James, the following exchange took place:

Q: Well, what did you talk about in August?

A: We had gotten a call to find out if Sherlie had been complaining prior about being in pain, that was a conversation in August.

Q: And said you got a call about that?

A: Yes.

Q: Who called you?

A: Well, no one called me directly, the person Christine Michaels who handles our Workman's Comp cases, asked me to find out if this was true.

Q: That Sherlie was complaining about her arm?

A: That she had been complaining prior, yes.

Q: Prior to August, right?

A: Yes.

Q: And you talked to Zelma about that, right?

A: Yes.

Q: And you talked to - - what is the other lady's name again?

A: Jean.

Q: Jean about that, correct?

A: Correct.

Q: And did both of them tell you about her arm?

A: Both of them said she had complained from time to time that she was still sore or different days was having pain.

Q: Now, as I understand it, the gist of your testimony, regarding Sherlie complaining about her arm, she was complaining about her arm being sore between January and August of 2011, is that right after the accident occurred?

A: I was asking them of resent, they didn't give a date.

The Petitioner's supervisors were trained that if one of the workers reports an inability to perform her job because of a physical problem, that supervisor is to report it to Ms. James. Ms. Daniels resigned in 2011 because she was not following policies and procedures. She received disciplinary warnings and counseling, but Ms. Daniels claimed that the counseling was affecting her health so she resigned.

When Ms. James talked to Jean Meko, Jean told her in August of 2011 that the Petitioner started complaining of her shoulder a month or couple of weeks earlier. The Petitioner worked on both the third and fourth floor. When she worked the third floor, Ms. Daniels was her supervisor. When she worked the fourth floor, Jean Meko was her supervisor. Neither Ms. Daniels nor Ms. Meko told her that the Petitioner was having difficulty doing her work.

Jean Meko testified that the Respondent has employed her as an LPN for sixteen years. She oversees and cares for the residents, makes assignments to the CNA's, monitors medication and makes sure that the residents are fed. In 2011, the Petitioner was one of the CNA's that she supervised. In July of 2011, she became aware of the Petitioner's shoulder complaints. Between January 11, 2011 and July 2011, she did not see the Petitioner every day, but frequently worked with her. The Petitioner worked on the fourth floor under the supervision of Ms. Meko approximately 60% of the time. The other 40% of the time, Petitioner would be on the third floor under the supervision of Ms. Daniels.

Ms. Meko testified that the Petitioner did not complain of shoulder problems until July of 2011. She never requested that she be given light-duty work prior to July of 2011. She never requested additional help in doing her work during that period of time. Ms. Meko further testified that while she was working between January and July of 2011, the Petitioner did not appear to be in pain.

Conclusions of Law

With respect to issue (F) "Is the petitioner's current condition of ill-being causally related to the injury?" the Arbitrator concludes as follows:

The Arbitrator finds that the Petitioner has failed to prove that her current condition of ill-being with respect to the right shoulder is causally related to her accident of January 11, 2011. The Arbitrator bases this finding on the following factors:

Although the Petitioner contends that she experienced ongoing problems with her shoulder from January 12, 2011 through the time she went for medical attention on August 30, 2011, substantial evidence indicates to the contrary. The history contained in the records of the Concentra Medical Center (Rx.3) for the visit of August 30, 2011 reflect that the Petitioner had pain in her shoulder only for three – four months prior to that visit, which means that it began in May or June of 2011.

Moreover, the records of the Aunt Martha's Medical Center (Px.5) reflect that the Petitioner was seen at that facility on March 22, 2011 and did not complain of shoulder problems. There is an undated Aunt Martha's record, which was apparently recorded after August 30, 2011, since it refers to treatment at Concentra. Such record refers to left shoulder pain and right shoulder pain.

Additionally, two credible witnesses, Aasta James and Jean Meko, both testified that they observed the Petitioner between January 12, 2011 and August 30, 2011. They testified that she did not appear to be in pain and did not report having any shoulder problems until July of 2011.

The Petitioner acknowledged that the Concentra doctor told her on January 12, 2011 that she was to return to him if she had any more problems, but that she chose not to do so. Her explanation that she had no insurance is not credible since she never received a bill from Concentra.

Although Zelma Daniels indicated that the Petitioner complained of shoulder pain, she could not be specific with respect to the dates (or even the months) on which Petitioner complained.

The Arbitrator notes that when Dr. Nicholson issued his causation opinion, he had not reviewed any treatment records because none were provided to him.

Moreover, none of Dr. Tu's treating records were offered into evidence and there is no statement in his narrative report to indicate that he had reviewed any records from Concentra Medical Center or Aunt Martha's Medical Center.

The Arbitrator accepts the opinion of Dr. Schiffman that there is no causal connection between her right shoulder condition of ill-being, about which she complained in late August of 2011, and her fall 8-1/2 months earlier.

The Arbitrator places a great deal of weight on the March 22, 2011 record of Aunt Martha's Medical Center and on the August 30, 2011 record of Concentra Medical Center.

With respect to issue (K) "Is Petitioner entitled to prospective medical care?" the Arbitrator concludes as follows:

The Petitioner seeks an order that the Respondent authorize the surgery prescribed by Dr. Tu to the right shoulder to address her diagnosed condition of impingement syndrome. The Arbitrator denies the Petitioner's request for the following reasons. Neither Dr. Kenneth Schiffman nor Dr. Gregory Nicholson has endorsed the proposed surgery. Dr. Nicholson indicated that the MRI was not diagnostic and no clinical decision should be based on the MRI. He also noted that all of the impingement signs were negative when he performed his physical examination. He felt that her pain was myofascial in nature. Dr. Schiffman bases his opinion on the fact that the Petitioner's complaints were diffuse and not consistent with rotator cuff pathology. As with Dr. Nicholson's exam, Dr. Schiffman also found negative impingement signs in his physical examination. The objective medical evidence does not support the Petitioner's request for surgical intervention.

With respect to issue (L) "What temporary benefits are in dispute?" the Arbitrator concludes as follows:

Based on the Arbitrator's finding with respect to causal connection, the Petitioner's request for temporary total disability benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sylvia Brooks-Clausell,

Petitioner,

vs.

NO: 07 WC 39619

14IWCC0033

Capitol Cement,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, benefit rates, medical expenses, wage differential, penalties, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 16, 2012, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

14IWCC0033

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
TJT:yl
o 12/17/13
51

Thomas J. Tyrrell

Kevin W. Lamborn

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLAUSELL, SYLVIA BROOKS-
Employee/Petitioner

Case# **07WC039619**

CAPITOL CEMENT
Employer/Respondent

14IWCC0033

On 11/16/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

1872 SPIEGEL & CAHILL PC
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15 SPINNING WHEEL RD SUITE 107
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STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

14IWCC0033

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sylvia Brooks-Clausell
Employee/Petitioner

v.

Capitol Cement
Employer/Respondent

Case # **07** WC **39619**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **October 4 and 5, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

On **May 15, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$68,952.00**; the average weekly wage was **$1,326.00**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$93,417.31** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$93,417.31**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $884.00/week from May 16, 2007 through August 31, 2009, a period of 119 6/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $884.00/week from September 1, 2009 through January 31, 2010, a period of 21 6/7 weeks, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits in the amount of $646.67 per week from February 1, 2010 through May 31, 2012, a period of 121 4/7 weeks, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits in the amount of $660.00 per week beginning June 1, 2012 and for the duration of Petitioner's disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner the stipulated fee schedule charges set forth in PX 31, subject to the exceptions discussed in the attached conclusions of law.

Respondent shall pay to Petitioner Section 19(k) penalties of **$50,186.58**, Section 16 attorney fees of **$20,074.63** and Section 19(l) penalties in the maximum statutory amount of **$10,000.00**.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator Molly C Mason

11/16/12
Date

NOV 16 2012

Sylvia Brooks-Clausell v. Capitol Cement
07 WC 39619

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Arbitrator's Findings of Fact

Petitioner, who was born on May 21, 1958, testified she stopped attending high school in 1977, after completing her sophomore year. She obtained her GED in 1982. T. 13-14.

Petitioner testified she attended a six-month EMT training course in 1983. She never worked as an EMT because she scored 78% rather than the requisite 80% on the final examination. T. 15.

In 1983 and 1984, Petitioner took classes in child development, English and psychology at Prairie State College. She did not obtain a degree at that time. T. 15-16.

In 1989, Petitioner began working in the asbestos removal trade after attending a one-week training course. She continued performing this work for three to four years. The job required her to wear a HAZ-MAT suit and a 30-pound oxygen tank. She testified she routinely lifted loads of wood weighing up to 60 pounds. T. 17. She received a "supervisor's license" at the end of the one-week training course, as did the other attendees, but never actually worked as a supervisor. She testified she stopped working as an asbestos remover because of the potential health hazards associated with the job. T. 19.

Between 1994 and 2000, Petitioner worked for Motorola, packing call towers into boxes. Petitioner testified she routinely lifted packed boxes weighing sixty to eighty pounds. T. 20. Her job consisted solely of manual labor. She had no management duties. T. 20-21.

Under cross-examination, Petitioner acknowledged that the application she submitted to Motorola reflects a typing speed of 65 words per minute. She testified she based this on a score she received following a high school typing test. T. 138. After she stopped working at Motorola, she took a typing test at a temporary agency and was told she scored only 35 words per minute. T. 138. She acknowledged the typing score she listed on her Motorola job application was probably not accurate as of the date she completed the application. T. 138-139.

Petitioner testified she last worked for Motorola at the end of 1999. T. 139. Motorola moved the plant's operations to Texas. Motorola offered job placement services to the displaced workers. Petitioner testified she availed herself of these services, and even traveled to Texas at Motorola's expense in an effort to find work, but did not receive any offers.

Petitioner testified she attended Columbia College, an "open enrollment" college, while she worked for Motorola. Motorola paid her tuition expenses. The $40,000 salary listed in her Motorola records does not represent her actual earnings, which totaled $21,000. The $40,000 figure includes tuition as well as those earnings. T. 139. Petitioner maintained a GPA of 3.1

and graduated from Columbia in 2000 (with an interdisciplinary degree in marketing and journalism) but testified she would not have been able to achieve this GPA and graduate without the help of tutors. She met with tutors three to four times weekly while attending Columbia College.

Respondent offered into evidence Petitioner's official transcript from Columbia College. This transcript reflects that, on admission, Columbia accepted 31.00 transferred hours from Prairie State and Lewis Colleges. It also reflects Petitioner received a "C" in an English composition class she took at Columbia in the spring of 1995, a "D" in an introductory media writing class she took in the fall of 1995 and a "C" in a journalism independent project class she took in the spring of 2000. Petitioner graduated from Columbia on June 3, 2000 with a cumulative GPA of 3.021 and a Columbia GPA of 3.2. RX 6.

In 2001, Petitioner paid $200 in order to attend a seminar sponsored by Primerica Insurance. During the seminar, Petitioner learned techniques for selling term life insurance. After the seminar, Petitioner, accompanied by a Primerica employee, tried selling insurance to friends and relatives but met with little success. She abandoned her efforts after six months. She testified she earned only $300 to $400 during that period. She denied any subsequent employment in the insurance industry.

Between 2001 and 2003, Petitioner lived in a 36-unit cooperative building on South Ellis in Chicago. Petitioner was president of the co-operative. Petitioner testified the building was in receivership due to code violations. As president, Petitioner was allowed to live for free in the building in exchange for appearing at court on a weekly basis in an ultimately unsuccessful effort to "save" the building. Petitioner denied receiving any other compensation for her efforts. T. 36.

Petitioner testified that, in 2001 or 2002, she briefly worked for SBC through a temporary agency. She was fired after about a month. She also did temporary work for a video company, putting VHS movies into cases. She earned about $8 per hour while performing this work. T. 37.

At a friend's recommendation, Petitioner applied to work as a substitute teacher for the Chicago Board of Education in November of 2004. Petitioner testified she did not have a teaching certificate when she applied. The application process consisted solely of submitting to fingerprinting and passing a background check. Records offered into evidence by Respondent reflect that Petitioner completed and signed a "Chicago Public Schools Employment Application" on October 15, 2004. Petitioner applied to work as a teacher. The portion of the application requesting information as to "state certificates held" is blank. RX 6.

Petitioner began working as a substitute teacher in late 2004. Petitioner testified she did not undergo any training before beginning to work in this capacity. She earned $82 to $89 for each day she worked.

In 2006, Petitioner began an apprenticeship program with the Cement Masons' Union. Petitioner testified that she typically performed cement finishing "up and down highways." She would work on her knees much of each day, using booms and "floats." She also unloaded wood from trucks.

The parties agree Petitioner was injured on May 15, 2007, while working as a cement finisher for Respondent. Arb Exh 1. Petitioner testified that Respondent was aware of her concurrent substitute teaching job. T. 41-42.

Petitioner denied having any problems with her lower back, left leg or left ankle prior to the May 15, 2007 accident. T. 43.

Petitioner testified that, immediately prior to the accident, she was standing in a trench while talking with a co-worker who was inside a Bobcat truck. The trench was 22 inches deep and Petitioner was standing on top of "stones layered with dirt." The Bobcat was 7 feet high and about 60 to 70 inches long. The driver of the Bobcat caught sight of a stone truck that looked as if it was about to fall over. The stone truck was behind Petitioner. The Bobcat driver gave a quick warning to Petitioner and almost simultaneously drove off. As the driver sped away, the Bobcat knocked Petitioner down, running over Petitioner's left leg in the process. T. 46.

After the accident, Petitioner underwent treatment at the Emergency Room at Mercy Hospital. The "initial assessment" notes reflect that Petitioner complained of 10/10 pain in her left leg from her knee to her foot secondary to a Bobcat running over her "foot/ankle/leg." An accompanying diagram shows abrasions on the left shin and a contusion on the dorsum of the left foot. Left foot X-rays showed "no evidence of acute fracture or dislocation." The attending physician diagnosed an "ankle/foot contusion." Petitioner received Motrin and Vicodin for pain. The Emergency Room physician applied an Ace wrap to Petitioner's left leg and instructed Petitioner to rest, apply ice, use crutches and follow up with her primary physician or employee health. PX 10. RX 5.

Petitioner followed up at MercyWorks Occupational Medicine on May 17, 2007. Dr. Sheth's note of that date sets forth a detailed and fully consistent history of the May 15, 2007 work accident. The doctor noted that, after the Bobcat driver "took off," Petitioner "found herself on the ground and sustained injury to her left ankle, left foot, left leg and left side of the lower back."

Dr. Sheth noted complaints of 9/10 pain and swelling over the left foot and ankle and 3/10 pain in the left leg and left side of the lower back. Petitioner indicated she was taking the pain medication prescribed at the Emergency Room and relying on crutches to walk.

On examination of Petitioner's left foot and ankle, Dr. Sheth noted "diffuse moderate swelling over the entire dorsum of the foot and bimalleolar ankle area" and an area of ecchymosis measuring 7 cm x 5 cm over the dorsolateral ankle. On examination of Petitioner's

left leg, Dr. Sheth noted "mild swelling over posterolateral leg and two areas of ecchymosis (measuring 7 cm x 5 cm and 5 cm x 2 cm) with abrasion over the mid and distal part present." On examination of Petitioner's left knee, Dr. Sheth noted no swelling, deformity or ecchymosis, no point tenderness, no effusion, no instability and a full range of motion. On examination of Petitioner's lumbar spine, Dr. Sheth noted no swelling, deformity or ecchymosis, mild tenderness at the left paraspinal lumbar area, forward flexion to the ankle, a full range of lateral motion with mild pain and straight leg raising to 70 degrees without pain.

Dr. Sheth diagnosed a crush injury to the left foot and ankle, abrasions and contusions to the left leg and a lumbosacral muscle strain. Dr. Sheth administered an injection, prescribed Ibuprofen and Hydrocodone and instructed Petitioner to stay off work, apply ice and then heat, elevate the left leg as much as possible, continue using the crutches and gradually resume bearing weight on the left leg as tolerated. PX 13.

Petitioner returned to MercyWorks on May 24, 2007 and saw Dr. Marino. The doctor noted complaints of pain in the left ankle, left foot and left lower back. He also noted continued swelling and tenderness in the lateral left foot and ankle. He kept Petitioner off work and instructed Petitioner to continue the medication and ice/heat application. PX 13.

Respondent offered into evidence a two-page ESIS "injury report for workers' compensation." This document appears to bear Petitioner's handwriting and signature. It is dated May 26, 2007. It reflects that Petitioner injured her "ankle, foot, leg, back – all left side" on May 15, 2007. RX 5.

Petitioner saw Dr. Marino again on May 31, 2007 and indicated her back pain was better but the Ibuprofen was not helping. Dr. Marino noted increased pain on all motion of the left foot and ankle. He kept Petitioner off work and prescribed Naproxen and Vicodin. PX 13.

On June 7, 2007, Petitioner saw Dr. Ali at MercyWorks, with the doctor noting a left-sided limp but improvement of the back pain. The doctor prescribed therapy and continued to keep Petitioner off work. PX 13.

On June 12, 2007, Petitioner returned to MercyWorks and saw Dr. Sheth. The doctor noted that "physical therapy was not called for approval until today." He also noted that Petitioner was still limping and requested a consultation with a "foot specialist." Dr. Sheth prescribed Hydrocodone, referred Petitioner to Dr. Perns and continued to keep Petitioner off work. PX 13.

Petitioner first saw Dr. Perns on June 13, 2007. Dr. Perns is a podiatrist associated with Midland Orthopedic Associates. Petitioner completed a "medical history" form describing her problem as "back – mainly foot crushed." Under cross-examination, Petitioner acknowledged she did not mention any knee problems on this form. T. 109. Petitioner also completed a form entitled "work-related injury." On this form, Petitioner identified "ESIS" as the "contact person or nurse specialist managing [her] claim." PX 4.

Dr. Perns' initial note sets forth a consistent history of Petitioner's May 15, 2007 work accident and subsequent treatment. Dr. Perns noted Petitioner was continuing to experience "intense pain to the entire left foot, ankle and lower leg as she began to walk on this over the last week." He described Petitioner's past medical history as unremarkable. Petitioner also complained of recent high blood pressure and lack of sensation when applying warm compresses to her affected left leg.

On initial examination, Dr. Perns noted mild edema of the left leg, a "great deal of discomfort and pain on light touch and palpation of the medial and lateral ankle ligament as well as the rearfoot and midfoot region, a positive Tinel's sign along the deep and superficial peroneal and sural nerve regions and a good range of motion of the ankle joint. He reviewed the X-rays taken at the Emergency Room and was unable to find any fracture or subluxation. His impression was: "1) crush injury with contusion on the left; and 2) neuritis on the left." He administered an anesthetic block into the left leg, placed Petitioner in an Unna boot, instructed Petitioner to bear weight and walk normally while using the boot and recommended therapy. PX 4.

Petitioner also saw Dr. Sheth on June 13, 2007, with the doctor keeping Petitioner off work and recommending "continue[d] management as per Dr. Perns." PX 13.

Petitioner returned to Dr. Perns on June 20, 2007 and indicated she experienced total pain relief following the injection, but only for eight to ten hours. Petitioner indicated the pain then "came back and felt like it was a hot poker stabbing her." Petitioner also complained of swelling toward the end of the day.

After Dr. Perns removed the Unna boot, he noted mild edema to the left leg, a "great deal of discomfort on light touch" and a positive Tinel's sign on percussion of the superficial and deep peroneal nerve regions of the left foot. He administered another "total ankle block" with "three injections to the left ankle." He instructed Petitioner to remain off work, wear a tube grip during the day and apply ice to her foot at night. He prescribed Ultram. PX 4.

When Petitioner next saw Dr. Perns, on June 27, 2007, she reported "more relief from the last injection" but again complained of a burning-type pain to the top of the foot extending around the outside of the ankle into the rearfoot. On examination, Dr. Perns noted a good range of ankle motion, very minimal edema and a positive Tinel's sign. He administered a third total ankle block and encouraged Petitioner to ice her ankle at night. He indicated Petitioner was going to start therapy the following week. PX 4.

Petitioner also saw Dr. Sheth at MercyWorks on June 27, 2007. Dr. Sheth described Petitioner's gait as follows: "still dragging her left foot with crutches." He described Petitioner's lumbar spine as unchanged since the last examination. He instructed Petitioner to start therapy, follow up with Dr. Perns and remain off work. PX 13.

Petitioner underwent an initial physical therapy evaluation at Mercy Hospital on July 10, 2007. The evaluating therapist, whose signature is not legible, indicated Petitioner was taking measurements of an excavation at a jobsite on May 15, 2007 when a Bobcat ran over her left foot and leg. The therapist described Petitioner as "ambulating independent with on crutch posture." The therapist described Petitioner's ambulation as "fair due to back pain." The therapist noted numbness, tingling and hypersensitivity of the dorsal aspect of the left foot. The therapist rated Petitioner's left foot and ankle pain at 7/10 and her low back pain at 4/10. PX 4. Petitioner attended therapy thereafter on July 12, 16, 18, and 19, 2007. PX 13.

Petitioner returned to Dr. Perns on July 23, 2007 and indicated she obtained relief from the last injection but was still experiencing "radiating tingling pain to the top of her left foot." On examination, Dr. Perns noted moderate edema to the forefoot and midfoot regions on the left foot. He also noted a positive Tinel's sign. He started Petitioner on Lyrica and recommended she perform range of motion exercises in warm water each morning and in ice a night. PX 4.

Petitioner also saw Dr. Sheth at MercyWorks on July 23, 2007. The doctor described Petitioner's gait as "normal with cane." He indicated Petitioner described her low back as "a lot better." He noted minimal to no swelling of the left ankle and foot. He indicated Petitioner "still jumps on slightest touch." He kept Petitioner off work and recommended she continue therapy and follow up with Dr. Perns. PX 13. Petitioner continued attending therapy on a regular basis thereafter. On July 30, 2007, the therapist noted improvement, with Petitioner describing her low back as 80% better and her left foot as 50% better. On August 1, 2007, the therapist recorded the following: "states rt knee is giving her problem and going up the stair knee gives out. Going to see doctor." The following day, the therapist indicated Petitioner was experiencing weakness and a "giving way" sensation in her right knee. PX 12. On August 16, 2007, the therapist discharged Petitioner from care, noting 90% improvement with respect to the low back and 80% improvement with respect to the left ankle and foot. In the discharge summary, the therapist indicated Petitioner was ambulating independently. The "assessment" portion of the discharge summary reads as follows:

> "Patient has reached max potential. Rt [sic] foot ankle function. No pain low back. Going next week to see specialist Dr. Maday for lt knee evaluation due to knee pain and lt knee gives out."

PX 4.

On August 20, 2007, Petitioner returned to Dr. Perns. The doctor noted improvement but indicated Petitioner was still experiencing "a little bit of discomfort to the outside of the ankle." He also indicated Petitioner denied further complaints. On examination, he noted mild residual edema to the left leg, a very good range of ankle and subtalar joint motion and "slight numbness to the distal tip of the fibula." He recommended that Petitioner continue her home exercises for a couple of weeks and return to work on September 4, 2007. He prescribed Lyrica and Tramadol and instructed Petitioner to return to him in a couple of months. PX 4.

On August 22, 2007, Petitioner saw Dr. Maday, another physician associated with Midland Orthopedic Associates. Petitioner completed new "medical history" and "work related injury" forms on August 22, 2007. The "medical history" form reflects that Dr. Perns referred Petitioner to Dr. Maday, that Petitioner had not yet undergone any knee treatment, that the knee problem had been "overlooked" at MercyWorks and that the problem was aggravated by using stairs. On the "work related injury" form, Petitioner provided the following response to the question: "describe why this is work-related":

> "Because when the Bobcat ran over my leg, I took a hard fall on stone, rock, etc. At the time, the pain was so very severe in my foot that it (the foot) seem [sic] to have been the doctor [sic] main focus. But other pain (or problem) surface[d] soon after."

[emphasis in the original]. Petitioner identified "Pat Galvin" as the "contact person or nurse specialist managing" her claim. PX 4.

Dr. Maday noted that Petitioner complained of bilateral knee pain and "originally injured her knees in a work-related incident which occurred on 5/5/07 [sic]." Dr. Maday described Petitioner as twisting and falling that day after a small vehicle drove over her left foot. He noted that Petitioner was currently undergoing treatment for her ankle "because this was deemed the most severe symptomatic injury." He indicated Petitioner complained of catching and popping in her knees, as well as "episodes of giving out, especially on the right knee." He described Petitioner's right knee as more symptomatic than her left. He also noted that Petitioner denied any previous history of knee problems.

On examination, Dr. Maday noted a full range of motion and negative McMurray's in both knees. Apparently referring to the right knee, he noted 1 to 2+ anterior medial and 1+ anterior lateral joint line tenderness and no other positive findings. Specifically referring to the left knee, he noted 1+ anterior medial and 1+ anterior lateral joint line tenderness and no other positive findings. He described X-rays as "essentially within normal limits." He assessed "possible meniscal pathology, status post fall" and recommended MRI scanning. PX 4.

At Respondent's request, Petitioner submitted to a Section 12 examination by Dr. Pinzur on August 21, 2007. Dr. Pinzur is a board certified orthopedic surgeon. He performs reconstructive foot and ankle surgery at Loyola University Medical Center. He has published extensively concerning foot and ankle conditions. RX 2, Pinzur Dep Exh 1. At his deposition, Dr. Pinzur described Petitioner as having sustained a crush injury to her left foot while working on May 15, 2007. Dr. Pinzur also indicated Petitioner had undergone "serial localized ankle blocks with some degree of temporary success." RX 2 at 8-9. He testified that, if Petitioner complained of knee pain, he did not note this in his report. RX 2 at 9.

When Dr. Pinzur examined Petitioner on August 21, 2007, he noted a "dynamic flat foot," mild swelling, diffuse tenderness without any localizing signs, "reasonable motion of the ankle and foot" and no neurological or vascular abnormalities. RX 2 at 9.

Dr. Pinzur's impression was that Petitioner was experiencing "delayed effects of a crush injury with neurogenic pain." He testified that Petitioner exhibited some of the characteristics of reflex sympathetic dystrophy. RX 2 at 10. He recommended an evaluation by a specialist in pain management and a sympathetic nerve block "to determine whether this process can be reversed." He indicated Petitioner should undergo a functional capacity evaluation if the nerve block failed to provide sufficient relief to enable Petitioner to resume working. He indicated that Petitioner "might be a reasonable candidate for an implanted spinal stimulator" if she had a "reasonable response to the sympathetic nerve block." He did not feel that continued local nerve blocks would provide any long term relief. Based on Petitioner's current condition, he found Petitioner "only capable of working at the United States Department of Labor sedentary or sedentary-light work levels." RX 2.

Petitioner resumed therapy at Mercy Health on August 22, 2007. Petitioner reported that Dr. Perns gave her a "new script to continue PT" for the left foot and ankle. Petitioner also reported that Dr. Maday prescribed MRI scanning. The therapist noted Petitioner was ambulating with a straight cane. PX 12.

On August 23, 2007, Petitioner returned to Dr. Sheth at MercyWorks, with the doctor indicating Dr. Perns sent Petitioner to Dr. Maday for bilateral knee pain. Dr. Sheth noted: "[Petitioner] states her right and left knee gave away 2 wks ago while going up stairs at home." Dr. Sheth also indicated Petitioner's knees had bothered her "since then." He noted Petitioner "was allowed to see Dr. Maday by Patrick Galion." RX 5. He described Petitioner's gait as "slow, favoring left side." He noted a full range of motion and no effusion or tenderness in both knees. He noted Petitioner was scheduled to undergo bilateral knee MRI scans.

On direct examination, Petitioner testified she began experiencing popping in her left knee "probably a few weeks after [she] started going to MercyWorks," while she was "on the crutches." Petitioner denied experiencing any popping in her left knee before the May 15, 2007 work accident. T. 97. Petitioner attributed her right knee pain to "the weight of bearing down" while using crutches. T. 50. Under cross-examination, Petitioner did not recall telling a physical therapist in August of 2007 that her knees had given way two weeks earlier while going up some stairs. Petitioner did, however, recall her knees giving way while climbing stairs. She attributed this to using crutches and/or knee pain. T. 112. She denied falling on stairs. T. 111-114.

On September 4, 2007, Petitioner filed an Application for Adjustment of Claim alleging a work-related injury of May 15, 2007 involving the "body as a whole." Arb Exh 2.

On September 5, 2007, the therapist at Mercy Health noted that "ins approved MRI" and that Petitioner's foot was improving.

On September 10, 2007, Petitioner underwent bilateral knee MRIs at AMIC. The left knee MRI demonstrated an "oblique tear of the posterior horn of the medial meniscus extending to the superior articular surface." The right knee MRI demonstrated a small joint effusion and mild medial and lateral chondromalacia. PX 7.

Petitioner returned to Dr. Maday on September 12, 2007. After reviewing the MRI results and re-examining Petitioner's knees, Dr. Maday diagnosed a medial meniscal tear of the left knee. He addressed causation as follows:

> "The patient's mechanism of injury, findings on examination and MRI are consistent with tear of the posterior horn of the medial meniscus. The patient did also note a knee injury at the time of her original injury and apparently this was documented on her chief complaint through the emergency room. Therefore, I believe this is directly a result of her work-related injury."

Dr. Maday discussed various treatment options, with Petitioner opting for surgery. Dr. Maday recommended that Petitioner stay off work pending the meniscal repair. PX 4.

Petitioner returned to Dr. Perns on October 1, 2007, with the doctor noting left foot and ankle improvement but continued complaints of tingling and some stiffness. The doctor indicated that Petitioner "states more of her problem is with the knee." On examination of Petitioner's left foot, Dr. Perns noted no real erythema or edema, "pretty good motion," a slight Tinel's sign and good strength. He described Petitioner's left foot and ankle condition as "resolving." He recommended that Petitioner "increase her activity level in regards to her foot." He released Petitioner from care with respect to the foot, noting Petitioner was still seeing his partner, Dr. Maday, for her knee. PX 4.

PX 4 contains a prescription slip bearing Dr. Perns' signature. The slip appears to be dated November 19, 2007. It states: "Sylvia can return to work as of 10/2/07." PX 4. There is no evidence suggesting Petitioner returned to work at this point.

Petitioner returned to Dr. Perns on December 3, 2007, with the doctor recording the following history:

> "Sylvia presents today and is still complaining of this burning pain to her left foot, ankle and lower leg. She states it is worse when she ties her shoes on tight or does long periods of standing and walking especially if she is carrying anything over 5 to 10 pounds. She denies any further complaints."

On examination, Dr. Perns noted "pain and discomfort to light touch and palpation to the plantar aspects of the entire left foot and medial and lateral midfoot region." Dr. Perns indicated he reviewed notes from Drs. Pinzur and Mercier. [No notes from Dr. Mercier are in evidence]. Dr. Perns prescribed EMG/NCV testing and instructed Petitioner to return to him as needed. PX 4.

Petitioner also saw Dr. Sheth at MercyWorks on December 3, 2007, with the doctor instructing Petitioner to remain off work and return to him after the EMG/NCV. PX 13.

On December 27, 2007, Petitioner underwent a consultation and EMG/NCV testing with Dr. Arayan of Health Benefits. Dr. Arayan obtained a consistent history of the May 15, 2007 work accident and subsequent treatment. Dr. Arayan noted the following complaints: 1) burning and tingling in the left anterior and lateral foot; 2) left leg weakness; 3) left knee pain; 4) lower back pain radiating down to the left knee and occasionally to the left foot; 5) occasional sweating and discoloration of the left foot; and 6) nail color changes in the left foot. Petitioner indicated these symptoms increased with walking, sitting and heat.

On examination, Dr. Arayan noted increased pain with lumbar spine flexion, decreased sensation in the left foot, slight left lateral foot edema, a positive slump test on the left and 5-/5 ankle plantar flexion on the left.

Dr. Arayan performed sensory and motor nerve conduction studies of both lower extremities. He rated the test results as "abnormal," noting "electrodiagnostic evidence of a chronic left L4-L5 lesion suggestive of a radiculopathy." He indicated that, along with this diagnosis, "one may want to consider complex regional pain syndrome as an additional diagnosis." He instructed Petitioner to follow up with Dr. Perns. PX 1.

Petitioner returned to Dr. Arayan on March 6, 2008. Petitioner complained of occasional pain in her left posterior knee and lower back. She also complained of more significant pain in her left ankle and foot, radiating up her left leg, and increased sweating in the left foot. She indicated her pain had increased since the preceding Sunday "with no inciting incident."

Dr. Arayan noted Petitioner had been off work since the accident and was "very anxious to get back to work." He also noted that Petitioner had been told she might need surgery for a left knee meniscal tear.

On examination, Dr. Arayan noted left paraspinal tenderness, decreased sensation in the left lateral leg, positive slight edema and increased sensitivity in the left foot and positive posterior knee fullness. He refilled Petitioner's Ultram prescription, started Petitioner on Lidoderm patches (to be applied to the left knee, ankle and foot), prescribed MRIs of the left foot and ankle and recommended Petitioner "follow up with orthopedic surgery for left knee medial meniscus tear." He instructed Petitioner to stay off work and return to him after undergoing the foot and ankle MRIs. PX 1.

Petitioner underwent the recommended MRI scans on March 15, 2008. She returned to Dr. Arayan on March 20, 2008, with the doctor describing the left ankle MRI as negative and the left foot MRI as showing "chondromalacia involving the first metatarsophalangeal joint with subchondral edema." Petitioner reported some improvement secondary to the Lidoderm patches. She complained of lower back pain radiating to her left leg and numbness and tingling in her left foot. She had not yet followed up with Dr. Maday for her left knee. Dr. Arayan recommended that continue the Ultram and Lidoderm patches, undergo lumbar spine X-rays, stay off work and seek follow-up care for her left knee. PX 1.

Petitioner underwent the recommended lumbar spine X-rays on March 31, 2008. She returned to Dr. Arayan on April 10, 2008, with the doctor interpreting the X-rays as showing mild anterior osteophytes at L1 and L4 and no acute fracture or subluxation. Petitioner indicated she had not yet seen Dr. Maday in follow up for her left knee. Petitioner complained of pain in her low back, left knee and left foot. Dr. Arayan reviewed the EMG and prescribed a lumbar spine MRI to evaluate Petitioner's radicular symptoms. He started Petitioner on Lyrica and refilled her other medications. He again recommended that Petitioner seek follow-up care for her left knee. He instructed Petitioner to return to him following the lumbar spine MRI. PX 1.

Petitioner underwent the recommended lumbar spine MRI on April 23, 2008. On April 28, 2008, Petitioner saw Dr. Watson, a pain management physician affiliated with Health Benefits. Dr. Watson obtained a consistent account of the work accident and reviewed the EMG and lumbar spine MRI. On examination, she noted a decreased range of lumbar spine motion and decreased sensation to light touch in the left L4, L5 and S1 distribution. She prescribed Vicodin and recommended transforaminal epidural steroid injections at L4-L5 on the left. She instructed Petitioner to remain off work. She administered the injection on May 1, 2008. PX 1.

On May 15, 2008, Dr. Watson administered a second epidural injection at L4-L5 on the left. She directed Petitioner to stay off work and prescribed physical therapy three times weekly for four weeks.

Petitioner returned to Dr. Arayan on May 21, 2008. On that date, Dr. Arayan interpreted the lumbar spine MRI as showing a small central disc protrusion at L5-S1 and a herniated disc at L4-L5, with "disc material extending into the neural foramen bilaterally, left greater than right." Petitioner complained of pain in her lower back radiating into her left leg. She also complained of pain in her left knee, ankle and foot. She reported some improvement secondary to the prescribed medication.

Dr. Arayan recommended a left L4-L5 selective nerve root block. He told Petitioner to stay off work and continue her medications. PX 1.

Petitioner returned to Dr. Watson on May 29, 2008. The doctor noted that the first two injections provided "good pain relief" but that Petitioner was still experiencing intermittent dull aches in the lower back and occasional pain and numbness in the left leg. On examination, Dr. Watson noted positive straight leg raising on the left. Dr. Watson administered a third epidural injection at L4-L5 on the left. She recommended that Petitioner see her primary physician for "new onset diabetes mellitus."

On June 11, 2008, Petitioner returned to Dr. Watson and reported that the third injection provided "approximately 85% to 90% pain relief." Straight leg raising was negative bilaterally. Dr. Watson instructed Petitioner to remain off work. PX 1.

Petitioner returned to Dr. Arayan on June 12, 2008 and reported about 85% improvement secondary to the three injections. Petitioner complained of 3/10 lower back pain, associated numbness in the left leg and foot and occasional giving way of the left knee. Dr. Arayan instructed Petitioner to discontinue the Vicodin. He refilled the other medications and again recommended orthopedic follow-up for the left knee. He prescribed therapy and continued to keep Petitioner off work. PX 1.

Petitioner saw Dr. Newman, an orthopedic surgeon affiliated with Midwest Orthopedics. Dr. Newman's history reflects that a Bobcat ran over Petitioner's left leg on May 15, 2007, with Petitioner being "knocked to the ground in an awkward position." The history also reflects that Petitioner complained of her left knee as well as other body parts at the Emergency Room the same day.

Dr. Newman noted that, while Petitioner was still experiencing some pain in the left side of her lower back and the lateral aspect of her left foot, her "main complaint" was her left knee, "which now buckles on occasion, particularly when she goes up stairs." Dr. Newman also noted intermittent left knee swelling.

On examination of Petitioner's left foot, Dr. Newman noted a complaint of tenderness on the lateral aspect but no discoloration or obvious swelling. On examination of Petitioner's lumbar spine, Dr. Newman noted some discomfort at end range of motion. On examination of Petitioner's knees, Dr. Newman noted exquisite tenderness along the medial joint line and a positive McMurray test in the left knee.

Dr. Newman addressed causation as follows:

> "In my opinion, the complaints that [Petitioner] has today are causally related to the incident that occurred on May 15, 2007. I think she sustained a strain of her lumbar spine, a crush injury to the left foot and ankle and a twisting injury to her left knee."

He described the foot and back treatment to date as appropriate. With respect to the left knee, he suspected a torn medial meniscus. Based on the MRI and the fact Petitioner complained of her left knee on the day of the accident, he found the left knee condition to be "directly related to the May 15, 2007 incident." He indicated Petitioner to be a candidate for arthroscopic surgery and recommended she stay off work. PX 6.

On August 15, 2008, Dr. Newman performed a partial medial meniscectomy and chondroplasty of the patella and trochlea. In his operative report, he noted a flap tear of the anterior horn of the medial meniscus. PX 6. T. 55.

At the first post-operative visit, on August 19, 2008, Dr. Newman noted no effusion and no evidence of infection. He prescribed physical therapy and instructed Petitioner to remain off work.

Petitioner testified that the knee surgery helped with the popping and pain. T. 55.

Petitioner returned to Dr. Arayan on August 21, 2008. Petitioner reported improvement in her knee condition secondary to the recent surgery. She also reported improvement in her back pain secondary to therapy. The doctor instructed Petitioner to continue the back therapy, start therapy for her knee, continue taking medication and stay off work. PX 1.

On September 9, 2008, Dr. Newman re-examined Petitioner's left knee. He noted a minimal effusion, a full range of motion and some crepitation. He instructed Petitioner to continue therapy and remain off work. PX 6.

On September 18, 2008, Dr. Arayan recommended that Petitioner undergo a neurosurgical evaluation for low back pain. He continued to keep Petitioner off work. PX 1.

On September 23, 2008, Dr. Newman issued a letter addressed "to whom it may concern" indicating that, while Petitioner could probably resume some restricted duties "as far as her knee is concerned," she needed to remain off work due to her lumbar spine issues. PX 6.

Petitioner saw Dr. Cerullo, a neurosurgeon associated with CINN, on October 1, 2008. T. 56.

Petitioner returned to Dr. Arayan on October 16, 2008. The doctor noted that Dr. Cerullo did not have access to Petitioner's lumbar spine MRI when he evaluated her. He also noted Dr. Cerullo's EMG recommendation He arranged to have both the MRI disc and the 2007 EMG report sent to Dr. Cerullo. He started Petitioner on Percocet and prescribed an electrical stimulation unit for home use. He instructed Petitioner to remain off work. PX 1.

On October 21, 2008, Petitioner returned to Dr. Newman. Dr. Newman noted only "very minimal anterior pain" in Petitioner's left knee. He discharged Petitioner from care with

respect to the knee but noted Petitioner was still off work and undergoing treatment for her back. PX 6.

On November 13, 2008, Dr. Cerullo prescribed a lumbar discogram. T. 57. Petitioner testified she was continuing to experience low back pain and radicular left leg pain at that time. T. 57.

On December 17, 2008, Petitioner and her then husband were involved in a motor vehicle accident. Following this accident, Petitioner went by ambulance to the Emergency Room at St. Bernard Hospital. Emergency Room personnel noted complaints relative to the back, head, right side of the neck and left shoulder. They also noted a history of "chronic pain, L4-L5 disc." RX 4, p. 3. Petitioner underwent X-rays of her cervical spine, chest, pelvis and left shoulder. There is no indication she underwent lumbar spine X-rays. RX 4, pp. 17-18. Petitioner received an injection of Toradol for pain. She was discharged from the hospital with a prescription for Ultram and instructions to seek follow-up care. RX 4.

Petitioner testified she again sought care at a hospital on December 19, 2008 due to nausea and pain. T. 58. Records in evidence show that Petitioner went to the Emergency Room at Mercy Hospital on December 29, 2008 and complained of nausea, vomiting, dizziness and lower back pain. Petitioner indicated her "meds [were] not working for pain." The Emergency Room records contain the following history:

> "The patient is a 50-yr-old female who presents with vomiting/diarrhea x 2 days and back pain since 12/17 after MVC. Pt states hasn't eaten in 24 hrs because of the vomiting . . . Back pain is severe after truck rear-ended her. H/o herniated disc. Worsened after accident. Denies LE weakness/numbness. + Myalgias."

RX 12, p. 47. The records also reflect that Petitioner provided a "hx herniated L4 & L5 from work injury" and was "also in MVA on 12/17." RX 12, p. 50. The Emergency Room physician, Dr. Trigger, diagnosed "viral syndrome with vomiting/diarrhea + exacerbation of chronic pain. Not c/w acute neurologic injury." RX 12, p. 46. Dr. Trigger administered an injection of morphine and ordered blood and urine testing. Petitioner subsequently reported improvement and was discharged with prescriptions for Vicodin and Zofran. She was instructed to seek follow-up care. RX 12, p. 50.

On direct examination, Petitioner testified that the December 17, 2008 motor vehicle accident caused only transient worsening of her back and leg pain. She also testified it took her about two weeks to heal from the accident. T. 58. Under cross-examination, Petitioner took issue with part of the history set forth in the Emergency Room records. The vehicle she was in was sideswiped, not rear-ended, by a semi. T. 119, 122. The back pain she complained of at the Emergency Room stemmed from being strapped to, and transported on, a wooden board. Petitioner testified that hospital personnel would not take her off this board until the

Emergency Room physician arrived to examine her. T. 120. Petitioner acknowledged telling hospital personnel that the motor vehicle accident caused her pre-existing back pain to worsen. T. 123. Initially, Petitioner denied being made a party to a lawsuit in connection with the motor vehicle accident. Ultimately, she acknowledged she was involved in a lawsuit to the extent her now ex-husband brought a claim against her automobile insurance. T. 124-125.

On January 29, 2009, Petitioner returned to Dr. Newman, with the doctor obtaining a history of the December 2008 motor vehicle accident. Dr. Newman indicated that a speeding truck jack-knifed, striking first the rear and then the passenger door of the car in which Petitioner was riding. The doctor also indicated that, following the second impact, the car "spun around and ended up facing in the opposite direction on the median." He noted Petitioner was transported to St. Bernard Hospital, where she complained of pain in her right knee and leg, head, neck, left clavicle and upper back. He also noted that Petitioner saw her primary care doctor on one occasion thereafter and had rested for three weeks after the accident so as to be well enough to take a pre-planned trip to the January 2009 inauguration. He described Petitioner's present complaints as limited to her neck, head, right knee and leg and left thumb. He noted no perceptible limp. On examination, he noted some feeling of stiffness in the neck, negative straight leg raising, no abrasions and tenderness along the lateral joint line as well as a positive McMurray test in the right knee. He ordered a right knee MRI and expressed concern "about a tear of the lateral meniscus." PX 6.

Petitioner returned to Health Benefits on February 3, 2009. She saw Dr. Rosania on that date, with the doctor noting Dr. Arayan had left the practice.

According to Dr. Rosania, Petitioner reported that "some of her medical care has been compromised by a recent motor vehicle accident sustained in December of last year which required evaluation at St. Bernard Hospital for right lower extremity discomfort." Petitioner indicated she remained off work and had recently completed her back and knee therapy.

On examination, Dr. Rosania noted positive seated straight leg raising bilaterally and "some trace left dorsiflexion weakness." He rewrote an order for a discogram "per Dr. Cerullo's recommendation." He indicated Petitioner might be a candidate for a repeat EMG. He renewed the Percocet and Flector patch prescriptions and continued to keep Petitioner off work. PX 1.

Petitioner underwent a three-level lumbar discogram on February 12, 2009. T. 59. Dr. Cha of Health Benefits performed this study. He noted "strong concordant pain" at L4-L5 "with reproducible radicular symptoms down the leg" at this level. He also noted concordant pain at L5-S1 "without the radicular symptoms." He noted only some degeneration at L5-S1. PX 1.

On March 27, 2009, Petitioner returned to Dr. Rosania and indicated she was having difficulty obtaining her medication "secondary to authorization issues." She also indicated she was having difficulty obtaining a copy of her 2008 lumbar spine MRI. Dr. Rosania reviewed the discogram results and recommended that Petitioner obtain the MRI films and return to Dr.

Cerullo to discuss surgery, stating: "it appears that the patient has exhausted conservative management for her condition." He renewed Petitioner's medications. PX 1.

On May 8, 2009, Petitioner returned to Dr. Rosania. The doctor noted Petitioner remained symptomatic but was "very motivated to return to work in some capacity if possible." On examination, he noted that straight leg raising now showed decreased hip range in flexion but no radicular pain. He renewed Petitioner's medications. He indicated Petitioner was still a surgical candidate but he released her to light duty on a trial basis, with no lifting over 20 pounds, no prolonged sitting and a "transition to part time duties." He instructed Petitioner to not take Percocet while at work. PX 1.

At Respondent's request, Dr. Ghanayem conducted a Section 12 examination of Petitioner on June 19, 2009. Dr. Ghanayem is director of the division of spine surgery at Loyola University Medical Center. He achieved board certification in orthopedic surgery in 1997. RX 1 at 5. He testified concerning his examination findings and opinions at a deposition conducted on May 17, 2010. RX 1.

Dr. Ghanayem noted Petitioner walked "with decreased stance phase on the left leg," meaning that Petitioner limped. RX 1 at 8. On lumbar spine examination, Dr. Ghanayem noted minimal discomfort at the base of the spine, 20 degree of extension, 60 degrees of flexion, no motor deficits, decreased sensation in the left leg from the mid-thigh down, normal reflexes and negative straight leg raising bilaterally. RX 1 at 8.

Dr. Ghanayem reviewed Petitioner's treatment records, lumbar MRI film and discogram results. He interpreted the MRI as showing degenerative disc disease at L4-L5. RX 1 at 10. He interpreted the discogram as "positive at a radiographically abnormal level and a radiographically normal level." RX 1 at 12, 15.

Dr. Ghanayem opined that the work accident caused a crush rather than a radicular-type injury and nerve damage to Petitioner's left leg. The nerve damage resulted in pain, sensory problems and a limp. RX 1 at 11. Dr. Ghanayem further opined that the limp resulted in some mechanical back pain, "hence the muscular findings on examination." He found Petitioner's condition to be appropriate for the stated mechanism of injury, i.e., having a machine run over her leg. He characterized Petitioner's leg problem as permanent and resulting in the need for work restrictions. RX 1 at 11, 17. He indicated Petitioner's leg problem prevented her from being able to resume working as a cement finisher. RX 1 at 17. He recommended that treatment be focused on the leg. He recommended against a spinal fusion, based on the discogram results. He testified that the "discogram report predicts a bad outcome from a fusion." RX 1 at 12.

While Dr. Ghanayem recommended physical therapy and possibly trigger point injections and/or orthotics for Petitioner's mechanical back pain, he also testified that Petitioner had achieved maximum medical improvement. RX 1 at 16-17.

Under cross-examination, Dr. Ghanayem testified that the work accident caused a soft tissue injury to Petitioner's back. RX 1 at 19. He also testified that he uses discograms in his practice. The discogram that Petitioner underwent was performed properly. RX 1 at 20. He disagreed with the radiologist's interpretation of the April 23, 2008 lumbar spine MRI to the extent that the radiologist characterized the abnormality at L4-L5 as a herniation. RX 1 at 21. Dr. Ghanayem viewed this abnormality as "more of a degenerative disc disease picture." RX 1 at 25, 30. Petitioner's left leg pain was circumferential, not radicular. He acknowledged, however, that the EMG was indicative of a radiculopathy in the left leg. RX 1 at 22-23. Drs. Cerullo and Onibokun diagnosed an L5 radiculopathy but "when you have a foraminal encroachment from a disc herniation at L4-L5, you don't pinch the L5 nerve root; you pinch the nerve that is in the foramen, which is the L4 nerve root." RX 1 at 24, 37. In order for the EMG to be consistent with the MRI, the EMG would have had to show an L4 radiculopathy. RX 1 at 24. With respect to Petitioner's discogram, the L5-S1 level produced concordant pain but was radiographically normal. It is this inconsistency that makes it inappropriate to recommend a fusion. RX 1 at 27. It is only if you interpret the discogram incorrectly that you could view L4-L5 as the pain generator. RX 1 at 31. Given that Petitioner is over the age of 40, the chance that L4-L5 is radiographically abnormal and not a pain generator is quite high. RX 1 at 35.

Dr. Ghanayem testified he did not review the case with an eye toward any malpractice issues. Thus, he could not comment as to whether it would be malpractice to proceed with a fusion. RX 1 at 33. If Petitioner does not have surgery, it would appropriate for her to undergo physical therapy for her back pain. RX 1 at 34. It is an "educated guess" on his part that Petitioner will not be able to resume working as a cement finisher. He believes a functional capacity evaluation would support that conclusion. RX 1 at 34.

Dr. Ghanayem testified that Petitioner's left leg condition falls into the category of reflex sympathetic dystrophy or complex regional pain syndrome. RX 1 at 38. The only precipitating event for this condition was the work accident of May 15, 2007. RX 1 at 38. If Petitioner undergoes a valid functional capacity evaluation and the evaluator determines Petitioner needs work restrictions, those restrictions would stem from the work accident. RX 1 at 39.

On redirect, Dr. Ghanayem testified that Petitioner might need chronic long-term medication for pain, along with monitoring. Dr. Ghanayem acknowledged he does not specialize in foot or ankle surgery. Dr. Pinzur is such a specialist. Dr. Ghanayem testified he would defer to Dr. Pinzur's opinions concerning Petitioner's foot condition. He refers patients with foot and ankle problems to Dr. Pinzur. RX 1 at 40.

Petitioner testified she decided against undergoing back surgery because she was afraid of ending up like her father, who is confined to a wheelchair. T. 60.

Petitioner testified she received temporary total disability benefits until the time of Dr. Ghanayem's Section 12 examination. T. 60.

At Dr. Rosania's recommendation, Petitioner underwent a functional capacity evaluation at Premier Physical Therapy on July 27, 2009. The evaluator, Ahmed Hassan, P.T., M.S., obtained a history of the work accident and subsequent treatment. He noted complaints of 4/10 lower back pain radiating to the extremities. He noted that these complaints increased with prolonged sitting, driving and repetitive activities. He noted positive straight leg raising on the left and an antalgic gait pattern favoring the left leg.

Hassan rated the evaluation as valid. He described Petitioner's overall performance level as "consistent throughout the evaluation." He found Petitioner capable of working at a light physical demand level, with a maximum of 15 pounds lifting shoulder to overhead, 18 pounds waist to shoulder and 18 pounds floor to waist. He noted that Petitioner was able to carry a maximum of 25 pounds for 20 feet but indicated that this weight was handed to Petitioner at waist level. He found it appropriate for Petitioner to participate in a rehabilitation program to address her physical deficits. PX 3.

Following the functional capacity evaluation, Petitioner returned to Dr. Rosania on August 31, 2009. Dr. Rosania released Petitioner to work within the limits of the evaluation.

Petitioner testified she began looking for alternative work on August 31, 2009. T. 62. She identified PX 20 as a compilation of the contacts she made with prospective employers. The first group of "employer contact sheets" in PX 20 covers the period August 31, 2009 through February 5, 2010. On these sheets, Petitioner documented approximately five or six job contacts per week. The first documented contact was with Chicago Public Schools. Petitioner testified she was "kicked out of" the Chicago Public Schools computer system as a result of being off work and drawing workers' compensation benefits for an extended period. Petitioner denied working as a substitute teacher at any point during the two years following her work accident. T. 64. When she contacted Chicago Public Schools in late August 2009, she was told no one was being hired. T. 64. Over the next few months, she contacted many cement finishing contractors looking for a flagging job, which she believed would be within her restrictions. She also made an unsuccessful attempt to obtain a clerical job at the office of her union local. T. 67. In late November 2009, she switched gears and began seeking work outside the cement finishing trade. The records in PX 20 reflect she contacted a variety of businesses looking for a cashier or clerk position. No one was hiring. T. 67-70.

Petitioner testified she began substitute teaching again in January of 2010. At this point, she earned $125 per day from Chicago Public Schools. T. 71. She primarily worked at Power House High School on South Homan. Initially, she worked only a few days per week. Over time, the school grew to appreciate her services and started asking her to substitute every day. As a substitute teacher, she is assigned to different classrooms, depending on teacher absences. She could be assigned to an English class one day and a geometry class the next. T. 75. She is not required to be up to speed on any particular subject. She does not develop lesson plans. She simply uses the assignments left by the regular teacher and presents those assignments to the class. She does not grade papers. She leaves completed coursework in the

regular teachers' mailboxes and the regular teachers "do their own grading." At times, she also worked as a hall monitor. T. 74.

Petitioner testified that, since January of 2010, she has not worked in any capacity other than as a substitute teacher. T. 76.

Petitioner testified she completed the third year of her cement mason apprenticeship and achieved journeyman status "in the academic sense" by attending three weeks of union-sponsored classes. T. 76-77. The union gave her a certificate of completion at the end of the three weeks. T. 76-77. After her work accident, she never again performed the physical duties of a cement mason. As of the accident, she was a second-year apprentice and fully intended to complete her training. T. 77. If she were currently working as a journeyman cement mason, her hourly wage would be $42.34. Assuming a 40-hour work week, her weekly wage would be $1,694.00. If she were currently performing both jobs, i.e., the cement mason job and a part-time substitute teaching job, her current weekly wage would be $1,694.00 plus $286.00. T. 78.

Petitioner testified that workers' compensation never interviewed her or provided her with vocational rehabilitation or job search assistance. T. 79. In 2010, she reviewed the labor market survey that Julie Bose conducted. At her attorney's direction, she contacted the employers identified in this survey and inquired about positions. One such employer asked her how she obtained their phone number and told her they have not hired in twenty years. That employer only had three employees. T. 81. Farmers Insurance, one of the employers identified in the survey, declined to interview her because she could not be an agent since she had filed for bankruptcy. T. 81. The Chicago Children's Museum, another listed employer, was not hiring. T. 82. The American Medical Association, another listed employer, was looking to hire a "director of clerk development," not a clerk. A job with American Global Life would have required her to relocate to Memphis. T. 82-83. In order to work at "Have Dreams," another listed employer, she would have needed a master's degree in marketing. T. 85. Adams Harris, another listed employer, was looking to hire someone to perform accounting, not marketing management. T. 85. She has no background in accounting. T. 86. Nielson required not only a master's degree but at least five years' experience in marketing. T. 86. Futurity First and Crump Insurance were not hiring. She contacted the listed insurance companies but was told she lacked experience to work in management. T. 86-89.

Petitioner testified that, after she contacted the employers identified in Julie Bose's labor market survey, she resumed looking for work on her own. She contacted McDonald's and Burger King. She also went "store to store" in two malls: Ford City and North Riverside. T. 91. She also dropped off resumes at different schools, looking for security-related jobs. T. 91. She also applied to work as an assistant to handicapped children who go to school by bus. T. 91. She also applied to work in the brain injury program at SEIU. She was familiar with this program because her handicapped son attended the program. She was not offered a job. T. 92.

Petitioner testified she could not resume asbestos removal because that job exceeds her restrictions. T. 92

Petitioner testified she last worked in July 2012. She was still looking for work as of the hearing. She met with Susan Entenberg, a vocational counselor, at her attorney's request. T. 93.

Petitioner testified she still experiences lower back pain that intermittently "shoots down" her leg. This pain is a "constant." Her left knee and left foot are "better." T. 97. Since she is a parent, she has to perform certain activities such as cooking and taking her son to doctors' appointments. Certain activities, such as sitting, bending and lifting, increase her symptoms. She takes Tramadol for pain at times. She also performs home exercises and uses a prescribed TENS unit. T. 95. She avoids wearing shoes with heels because doing so causes back pain. T. 96. Her pain affects her sleep. She tries to live within her restrictions. T. 96-97.

Under cross-examination, Petitioner testified she began working for Respondent in 2006. She was a second-year apprentice at the time of the accident. T. 99. When she went to the Emergency Room on the day of the accident, she complained of back pain but no one recorded this complaint. T. 100. She did not undergo any back X-rays at the Emergency Room. T. 101-102. She was diagnosed with foot and ankle contusions. T. 102. While she was undergoing treatment at MercyWorks, she asked to see a knee specialist. T. 106. She could not recall when she made this request. T. 107. She could not recall asking to see a back specialist. T. 108. When she completed a form at Midland Orthopedic Associates on June 13, 2007, she mentioned her back and foot but not her knee. T. 109. RX 9. She did not recall telling Dr. Sheth her back was "a lot better" in July of 2007. T. 110-111. Her knees gave way while she was climbing stairs but she did not fall on stairs. T. 112, 114. She complained of her knee in the Emergency Room on the day of the accident. T. 113. It was not the giving way on stairs that prompted her to complain of her knees. She complained of "clicking" in her left knee. T. 114. Dr. Perns released her from care with respect to her foot and ankle in October 2007. T. 115. She complained of low back and radiating leg pain before she saw Dr. Arayan on December 27, 2007 but no one recorded this complaint. T. 116-117. She has not undergone any left knee treatment since Dr. Newman released her on October 21, 2008. T. 117. She was involved in a motor vehicle accident on December 17, 2008. This accident occurred on 57. She was sideswiped, not rear-ended, by a semi. The impact caused her car her spin around. The car ended up in the median, facing the opposite direction. T. 119. The motor vehicle accident was bad enough that she went to the hospital via ambulance the same day. T. 119. She complained of back pain at the hospital. The back pain stemmed from being placed on, and strapped to, a wooden board while being transported to and waiting to be seen at the hospital. This worsened the back problem she already had. T. 120. She complained about the board at the hospital. T. 121. On December 29, 2008, she went to Mercy Hospital and complained of severe back pain. If the Mercy Hospital records state she was rear-ended by a truck on December 17, 2008, the records are incorrect. T. 122. She told the doctors at Mercy Hospital she had previously herniated a disc in her back and her back symptoms worsened after the motor vehicle accident. T. 123. Her ex-husband was in the vehicle with her at the time of the accident. She initially testified she was never named as a defendant in any lawsuit stemming from this accident. She then acknowledged that her ex-husband brought a claim against her auto insurance due to the accident. T. 124. Dr. Onibokun first recommended a fusion in March

of 2009. This is the first time any doctor recommended back surgery. T. 126. She could not recall whether she told Dr. Ghanayem about the motor vehicle accident. T. 128. She took two years of nursing classes but never received a nursing degree. T. 131. She would not have passed the courses she took at Columbia College had she not obtained tutoring. She saw a tutor three or four times per week. The tutor corrected her papers. She was able to graduate from Columbia College. T. 133. When she applied to work for Chicago Public Schools in 2004, she indicated she could communicate to some extent in Spanish and Japanese. She also indicated she had computer skills. T. 135-136. She further indicated she worked for Primerica Insurance from January of 2000 through January of 2003 but that was not correct. T. 136-137. When she applied to work for Motorola, she completed a form indicating she could type 65 words per minute but she cannot type at that speed now. T. 138. In completing the form, she relied on a typing score she received when she was a sophomore in high school. T. 138. After leaving Motorola in late 1999, she took a typing test at a temporary agency and scored only 35 words per minute. T. 138-139. She recently went online and reapplied to Motorola to work in management. She has not followed up on this. T. 141. She completed the coursework required of a third-year cement mason apprentice. The union website states that an apprentice must complete 6,000 hours in the field in order to become a journeyman. She did not put in these hours. Nobody did. T. 143. She is still paying union dues. T. 144. She did not tell Susan Entenberg she completed her apprenticeship. It could be that she was still taking classes through the union when she met with Entenberg. T. 145. Her attorney gave her job search forms to complete. Those forms are in PX 20. T. 145-146. She could physically perform the duties of a flagger. T. 147. In 2009, she applied to work as a manager at McDonald's. If the form states she applied to work as a flagger at McDonald's, the form is incorrect. T. 147-148. She relied on a union booklet when applying to work as a flagger. The booklet lists all of the mason contractors. T. 149. She applied to some, but not all, of the prospective employers identified in Julie Bose's labor market survey. T. 150. Some of the job contacts she made are not reflected in the documents in PX 20. She had a lot of job search records and some check stubs in her car. One day she cleaned out her car and set these documents down. Someone walked off with them. T. 151. Her normal workday as a cement finisher began at 7:00 AM and lasted until 3:30 PM. Her hours as a substitute teacher are from 8:30 AM until 2:30 or 3:30 PM. She would not be able to perform each of these jobs on the same day. T. 153-154. She was paid for a 40-hour work week during her apprenticeship. T. 154. No doctor has restricted her from working as a substitute teacher. T. 154. She last saw Dr. Rosania in 2010, at which point he told her to return to him on a monthly basis. Between her last visit to Dr. Rosania and 2011, she periodically went to doctors and hospitals to get morphine shots for pain. She does not have any of those records available. T. 155-156.

On redirect, Petitioner testified that it was her right knee that gave way when she climbed stairs. She was at home, using two crutches, when this happened. T. 157-159. She did not get hurt at that time. T. 159-160. She recalled using crutches for about two months after the work accident. T. 158. Her back pain waxed and waned. It never fully resolved. T. 160. In November of 2008, about a month before the motor vehicle accident, Dr. Cerullo ordered a discogram and told her she was a candidate for back surgery. T. 161. The motor vehicle accident did not result in any serious low back injury. T. 162. Dr. Ghanayem spent about five

minutes with her. He told her he was in a hurry and had to leave. T. 162. No professional helped her with her job search. She used her friends and relatives as resources. T. 168.

Under re-cross, Petitioner testified that there is only limited work available in the construction industry because unemployment is so high. T. 169-170.

In addition to the evidence previously summarized, Petitioner offered Dr. Cerullo's deposition of May 17, 2012. PX 19. Dr. Cerullo testified he is a board certified neurosurgeon. He has practiced neurosurgery in Illinois since 1977. PX 19 at 5. He no longer operates but did perform spine surgery for forty years. PX 19 at 5.

Dr. Cerullo testified he first saw Petitioner on October 1, 2008. Dr. Arayan referred Petitioner to him. Petitioner told him she was well until May 2007, when a Bobcat rolled over her left leg at work. PX 19 at 6. She injured her knee in the accident. She complained of back pain as well but her knee problem overshadowed her back problem. PX 19 at 6. She did not undergo a lumbar spine MRI until August of 2007. The MRI showed degenerative disc disease at L4-L5 and L5-S1. Petitioner underwent both therapy and epidural steroid injections but "both aggravated her symptoms." PX 19 at 7.

On October 1, 2008, Petitioner complained of back and leg pain as well as left leg tingling. She reported taking Lyrica, Vicodin and Tramadol. PX 19 at 7. On examination, Dr. Cerullo noted a moderate degree of paralumbar spasm but a fairly good range of motion of the back. PX 19 at 7-8. Straight leg raising was limited to 60 degrees bilaterally. PX 19 at 8. The examination indicated Petitioner had a combination of mechanical low back syndrome and sciatica. PX 19 at 8. He recommended a repeat lumbar spine MRI and EMG/NCV testing of the left leg. PX 19 at 8. At the next visit, on November 13, 2008, he reviewed an MRI and EMG/NCV test results. The EMG was "positive for radiculopathy" and the MRI showed degenerative disc disease with narrowing of the foramen at L4-L5. He felt that the L4-L5 disc "probably should be treated surgically" but, in order to "cement" a diagnosis, he ordered a discogram. PX 19 at 9. The examination, MRI and EMG constituted objective evidence supporting Petitioner's complaints. PX 19 at 9-10. Petitioner subsequently underwent the discogram, which was "physiologically and radiographically concordant at L4-L5 and questionably physiologically concordant at L5-S1." Dr. Cerullo testified that the discogram "cemented in [his] mind that the L4-L5 disc was the culprit." He referred Petitioner to one of his partners, Dr. Onibokun. Dr. Onibokun subsequently evaluated Petitioner and found her to be a candidate for an instrumented posterior lateral fusion at L4-L5 as well as a discectomy at L4-L5. PX 19 at 12.

Dr. Cerullo opined, within a reasonable degree of medical and surgical certainty, that the work accident of May 15, 2007 caused Petitioner's previously asymptomatic degenerative disc disease to become symptomatic. PX 19 at 12-13. Petitioner had two choices. She could either live with her pain or undergo surgery. PX 19 at 13. Dr. Cerullo further opined that the need for the surgery recommended by Dr. Onibokun stems from the work accident. PX 19 at 13. If Petitioner opted not to undergo the recommended surgery and instead underwent a

functional capacity evaluation, that would be reasonable. PX 19 at 13-14. If the evaluation was valid and indicated the need for restrictions, he would find the evaluation reliable. PX 19 at 14.

Dr. Cerullo testified he disagreed with Dr. Ghanayem's opinion that the work accident caused only a muscular or soft tissue back injury. He disagreed because Petitioner had positive symptoms which were appropriate for her pathology and she failed to improve with conservative measures. PX 19 at 14-15. Dr. Cerullo also disagreed with Dr. Ghanayem's opinion that Petitioner's leg pain was not radicular in nature. Petitioner's leg pain was "anatomically correct and corroborated by electrophysiologic study." PX 19 at 15.

Dr. Cerullo testified he reviewed the actual MRI film and not just the report. PX 19 at 15.

Under cross-examination, Dr. Cerullo clarified that, on November 13, 2008, he reviewed an EMG performed in December of 2007 and an MRI taken on April 23, 2008. PX 19 at 17. After he reviewed the EMG and MRI, he concluded that Petitioner was suffering from an L5 radiculopathy on the left, secondary to a herniated disc and degenerative disc disease at L4-L5. PX 19 at 17. He ordered but did not actually perform a discogram. PX 19 at 17-18. The discogram results could be consistent with degenerative changes or with an impact from a motor accident. PX 19 at 18. He referred Petitioner to Dr. Onibokun because he no longer operates. PX 19 at 20. He last saw Petitioner almost three years ago. He relied on Petitioner's history in formulating his opinions. Petitioner did not inform him she was involved in a subsequent motor vehicle accident. PX 19 at 20.

Petitioner also offered into evidence deposition testimony taken from Susan Entenberg on May 10, 2010 (PX 17) and April 7, 2011 (PX 18). On May 10, 2010, Entenberg testified she has worked as a vocational rehabilitation counselor since 1977. About half of her practice involves working in the workers' compensation arena. PX 17 at 4-5. She also works as a consultant for the Social Security Administration on a contract basis. PX 17 at 5-6. At the request of Petitioner's counsel, she met with Petitioner and issued a report on March 3, 2010. PX 17 at 6-7. Entenberg Dep Exh 2. Based on her meeting with Petitioner, the functional capacity evaluation and Dr. Arayan's imposition of restrictions consistent with the evaluation, Entenberg opined that Petitioner cannot resume her former occupation as a cement mason. PX 17 at 8. A cement mason's job is heavy and Petitioner is restricted to light demand work. PX 17 at 9. At her recommendation, Petitioner went back to the Chicago Board of Education, reintroduced herself and secured work as a substitute teacher. PX 17 at 10.

Entenberg testified that Petitioner obtained EMT certification but would not be able to work as an EMT due to the heavy physical demands of that job. For the same reasons, Petitioner would not be able to resume working in the asbestos removal trade. PX 17 at 10-11. Petitioner obtained a degree in television broadcast journalism in 2000 but has never worked in that field. Given Petitioner's age and lack of work experience in the field, it would be "next to impossible" for her to break into the world of journalism. PX 17 at 12. It would also be very difficult for Petitioner to work in marketing. She lacks the background for this. PX 17 at 12.

Entenberg testified that, of all of Petitioner's former occupations, substitute teaching is the one to fall back on. PX 17 at 13. Entenberg did not recommend any additional training because Petitioner is working. Further training would not increase Petitioner's earning power as a substitute teacher. PX 17 at 13. Any transferable skills Petitioner has at this point stem from her substitute teaching background. PX 17 at 13-14. Petitioner is currently earning between $15.50 and $16.00 per hour. Petitioner has experienced a wage loss because, if she were currently working as a cement mason, she would be earning $43.00 per hour. PX 17 at 14. Petitioner's current earnings are "very reasonable given her background, her work experience, her age and her education." PX 17 at 14.

Entenberg testified that, to her knowledge, Respondent has not offered Petitioner any vocational rehabilitation. PX 17 at 15.

Under cross-examination, Entenberg testified that she met with Petitioner on October 28, 2009. She had several telephone conversations with Petitioner after that date. PX 17 at 16. She did not generate a report until March of 2010 because she wanted Petitioner to return to the Chicago Board of Education first. PX 17 at 17. Petitioner did not need help preparing a resume. Since Petitioner has a bachelor's degree, she assumes that Petitioner is able to read, write and perform math at a high school level, at a minimum. PX 17 at 17. Petitioner is "personable, communicative and assertive." Petitioner did not require help with interview skills. PX 17 at 18. Entenberg testified she charged Petitioner's attorney $720 for her consultation. PX 17 at 18. She is charging $150 per hour for her deposition testimony. PX 17 at 19. Petitioner attended Columbia College, not Columbia University. The two schools are very different. PX 17 at 20. Petitioner received an asbestos removal supervisor's license in 1992 but, if Petitioner was a working supervisor, her job would not have been light. PX 17 at 21. When Petitioner worked for Primerica between 2000 and 2002, she sold life insurance "door to door." PX 17 at 23. Petitioner is familiar with Word and E-mails. She could perform entry-level clerical work. A typing score of 65 words per minute is "average to high average for a professional typist." PX 17 at 24. When Petitioner worked for Motorola between 1994 and 2000, she worked on an assembly line. She was a lead person on the line by the end of that employment. Entenberg testified she did not contact Motorla to inquire about openings because Motorola has been downsizing for years. PX 17 at 25. Entenberg testified she did not have a good feel for the type of work Petitioner performed for the Ellis Corporation between 2002 and 2004. PX 17 at 25. Before October 28, 2009, Petitioner had submitted about 25 resumes and had tried to get on some contractors' lists. PX 17 at 26.

At her second deposition, on April 7, 2011, Entenberg testified she reviewed a report and labor market survey prepared by Respondent's vocational consultant, Julie Bose, and issued a letter on April 4, 2011, setting forth her opinions concerning Bose's conclusions. PX 18 at 4. Entenberg did not view teaching as a reasonable career path for Petitioner. Petitioner has no education credits and no teaching certificate. It would take Petitioner a couple of years to return to college and obtain certification. PX 18 at 5. Additionally, lots of young graduates are currently looking for teaching jobs, which are "few and far between." PX 18 at 9. Entenberg

opined that marketing management is not a realistic option for Petitioner because Petitioner has never worked in the marketing field. PX 18 at 6. There is no stable labor market for Petitioner to work as an insurance salesperson. Petitioner is not currently licensed to sell insurance. She was last licensed in 2002 and has no current customer base. PX 18 at 6-7. It would be appropriate for Petitioner to work as an administrative assistant. The Department of Labor statistics reflect that the starting wage for an administrative assistant is $17.60 per hour. PX 18 at 7-8. Petitioner is still working as a substitute teacher and still earns $125 per day. PX 18 at 8. Substitute teaching is reasonable for Petitioner. She has been performing this work and the work falls within Petitioner's physical restrictions. PX 18 at 8. Entenberg disagreed with Bose's opinion that Petitioner has not lost earning capacity. That opinion is based on the earnings of insurance sales managers and marketing managers. PX 18 at 10.

Under cross-examination, Entenberg testified that, in most jobs, earnings are based on skill sets. From a statistical point of view, the fact that Petitioner has a bachelor's degree puts her in the upper percentage of the United States population. PX 18 at 11. The fact that Petitioner has a college degree does not mean that she has good writing skills. PX 18 at 12. Petitioner has more transferable skills than an individual who began working as a cement mason right after high school. PX 18 at 13. Entenberg testified that, to her knowledge, Petitioner and her husband operated Ellis Corporation. The job Petitioner performed for this corporation was not full-time. PX 18 at 14. Entenberg acknowledged she did not contact any prospective employers. She conceded it is possible Petitioner would qualify for an entry-level marketing position. PX 18 at 15. She assumes there is a high rate of unemployment in the construction trade at the present time. PX 18 at 16. She has acted as a consultant in two other cases being handled by Petitioner's attorney. PX 18 at 16.

Petitioner also offered into evidence a certificate issued by the United States Department of Labor, Office of Apprenticeship, indicating Petitioner completed an apprenticeship for the occupation of cement mason on August 17, 2009, under the sponsorship of the Cement Masons' Local 502 in Bellwood, Illinois and "in accordance with the basic standards of apprenticeship established by the Secretary of Labor." PX 21. Respondent did not object to the admission of this certificate into evidence.

Petitioner also offered into evidence wage scale documents from the Cement Masons' Union, Local 502, dated May 16, 2009 (PX 27), July 23, 2010 (PX 28), May 23, 2011 (PX 29) and May 16, 2012 (PX 30). Respondent did not object to any of these exhibits. PX 27, 28 and 29 reflect that a cement mason journeyman's hourly wage was $41.85 as of June 1, 2009, August 1, 2010 and June 1, 2011. PX 30 reflects that, as of June 1, 2012, a cement mason journeyman's hourly wage was $42.35.

Petitioner also offered into evidence fifty-six paychecks from Henry Ford Academy – Power House High. PX 32. These checks were issued during three intervals: February 11, 2010 through June 15, 2010, October 21, 2010 through June 16, 2011 and August 25, 2011 through June 21, 2012. They reflect total earnings of $49,450.40. Notations on the checks show that

Petitioner was paid for substitute teaching, tutoring and, on one occasion, security-related work. The Arbitrator notes that both the pay periods and earnings are irregular. During some months in 2010, Petitioner was paid only twice. In February of 2010, the checks total $1,625.00 whereas in October 2010 the checks total $500.00. The checks issued in 2011 total $24,604.40. The checks issued in 2012 (through June 21, 2012) total $11,048 and are particularly erratic in terms of issuance dates and amounts. In January and April of 2012, the checks totaled $227.50 and $450.00, respectively. By May of 2012, checks were being issued almost weekly and the payments were significantly larger. In May of 2012, checks were issued in the following amounts: $845.50, $750.00, $562.50 and $2,500.00. The following month, checks were issued in the following amounts: $1,025.00, $1,087.50, $1,050.00 and $300.00.

Respondent offered into evidence the deposition of Julie Bose, a certified vocational rehabilitation counselor. RX 3 at 6. Bose owns and operates MedVoc Rehabilitation. RX 3 at 5. Bose Dep Exh 1. She obtained a master's degree in rehabilitation from the Illinois Institute of Technology and has taught classes at the same institution as an adjunct professor. RX 3 at 5.

Bose testified she reviewed Petitioner's transcript from Columbia College along with the functional capacity evaluation and employment records from Motorola and Chicago Public Schools. RX 3 at 7. Based on the functional capacity evaluation, she opined that Petitioner was unable to return to her former cement mason trade. RX 3 at 9.

Bose testified she prepared a report on August 16, 2010, at which point Petitioner was working part-time as a substitute teacher. RX 3 at 9. Bose also prepared a labor market survey.

Bose described Petitioner as a "very well-educated individual who has a very varied work background." Bose testified that Petitioner has no readily transferable skills from her cement mason job. In her opinion, Petitioner's best vocational alternative would be to either "take additional classes to become certified in teaching" so as to "perhaps work as a full-time teacher" or utilize her previous education and work experience and obtain as job as a marketing manager, an insurance sales manager or an administrative assistant. RX 3 at 11.

Bose testified that Petitioner's earning capacity would vary depending on which of these avenues she pursued. If Petitioner obtained her teaching certificate and found a job as a teacher, she could anticipate earning $47,000 to $62,000 per year. RX 3 at 11-12. If Petitioner opted to become an administrative assistant, she could anticipate entry-level earnings ranging from $14.00 to $22.00 per hour. The mean entry level wage would be $17.60 per hour. RX 3 at 13. Bose opined that Petitioner would be capable of earning more than the entry level wage because "it's atypical for an administrative assistant to have a bachelor's degree." RX 3 at 14. If Petitioner secured a job as a marketing manager, she could anticipate earning $26.40 per hour in an entry-level position. In the insurance management industry, Petitioner's earning capacity could range widely from $21.87 to $31.30 per hour. RX 3 at 12.

Bose testified she surveyed only non-teacher positions because teachers' wages are a

matter of public record. RX 3 at 13. While conducting the survey, she contacted several prospective employers and advised them of Petitioner's educational background, work experience and physical limitations. The prospective employers who agreed to respond to the survey indicated that Petitioner "has the background they would be looking for in marketing management." These employers quoted various starting hourly wages. The mean wage was $26.40. RX 3 at 15. Bose also contacted employers to inquire about starting wages for sales managers. She primarily contacted employers "in the insurance arena" because of Petitioner's "experience at Primerica and Ellis Corporation in insurance sales and management." Each of the employers she contacted indicated that Petitioner had the experience and education necessary to be considered for employment. The starting entry level hourly wage varied from $16.80 to $40.87, with a mean of $31.30. RX 3 at 15-16.

Under cross-examination, Bose acknowledged she never met with Petitioner. Bose did not know the extent of Petitioner's computer skills. It was her understanding that Petitioner's job at Ellis Corporation primarily involved sales management. RX 3 at 19. She did not know whether Petitioner received a salary from Ellis Corporation. RX 3 at 20. When she completed the labor market survey, she told prospective employers that Petitioner had a bachelor's degree and experience in insurance sales. RX 3 at 19. Petitioner lacks a teaching certificate but she was "trained to be a substitute teacher." Chicago Public Schools requires substitute teachers to go through a formal training program to learn how to create lesson plans and conduct classes. RX 3 at 21. Bose testified she lacks "specific statistics" concerning the current job market for teachers. RX 3 at 22. Petitioner performed a marketing internship at Columbia College and got an "A" in this course. Petitioner also "worked as a district lead for Primerica, which utilizes marketing skills." RX 3 at 23. When Bose talked with prospective employers, she told them Petitioner had a marketing degree but no marketing experience. RX 3 at 24-25. Each of these employers told Bose they "had hiring needs." They also told Bose that Petitioner "had the appropriate education, work background and physical capabilities" to obtain a marketing management position. RX 3 at 25. Bose acknowledged Petitioner obtained her marketing degree over a decade ago. RX 3 at 26. Bose also acknowledged Petitioner is no longer licensed to sell insurance. Insurance sales are commission-based but insurance sales managers typically receive both commissions and wages. RX 3 at 26-27. Even though Petitioner has not been involved in insurance sales for a significant period, it is not impractical to think she could start out earning $31 per hour in this industry. RX 3 at 27. To say that Petitioner could immediately earn $31 per hour is to speculate. Petitioner would have to "go and interview, be offered a job and work that job successfully." RX 3 at 30. Most of the classes Petitioner took at Columbia College were "interpersonal-based." RX 3 at 29. Petitioner's current substitute teaching job is appropriate in terms of Petitioner's physical needs and work history but it is "underemployment." RX 3 at 29.

On redirect, Bose clarified that she contacted five prospective employers concerning a marketing manager job. RX 3 at 30-31.

Respondent also offered into evidence a document that was apparently downloaded

from the Cement Masons' Local 502 website. RX 13. This document reflects that "the term of apprenticeship shall be 6,000 hours (3 years) of work experience and 144 hours of related instruction, per year during apprenticeship term." The document also reflects that apprentices "start at 70% of the journey workers' hourly wage rate, increasing progressively to 100% by graduation." Petitioner raised no objection to the admission of RX 13 into evidence.

Arbitrator's Credibility Assessment

For the most part, Petitioner was an engaging and likeable witness. She became somewhat defensive under cross-examination, particularly when being questioned about her claimed knee condition and the December 2008 motor vehicle accident, but did not lose her composure.

There were some discrepancies between Petitioner's testimony and her medical records. There were also discrepancies between Petitioner's testimony as to her daily wage as a substitute teacher and the earnings reflected in the paychecks in PX 32. On the whole, however, the Arbitrator found Petitioner to be credible.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between her undisputed work accident of May 15, 2007 and her various claimed conditions of ill-being?

The parties agree that Petitioner sustained an accident while working for Respondent on May 15, 2007. Petitioner claims that this accident resulted in injuries to her left foot, ankle, knee, leg and lower back. At the hearing, Petitioner described her left foot, ankle and knee conditions as improved. Her most significant problem is the pain that radiates from her lower back down her left leg. T. 96-97.

The Arbitrator finds that Petitioner established causation with respect to her left foot and ankle conditions of ill-being. Petitioner testified that a Bobcat ran over her left foot and leg. Emergency Room personnel noted contusions and abrasions to the left foot and ankle on the day of the accident. They also noted that Petitioner was having difficulty bearing weight on her left foot. Petitioner left the hospital wearing a boot and relying on crutches. Two days later, Dr. Sheth at MercyWorks noted moderate swelling over the entire dorsum of the left foot and bimalleolar ankle area. He also noted ecchymoses and abrasions. He diagnosed a crush injury. PX 13. Petitioner's left foot and ankle problems persisted thereafter. While Dr. Sheth initially suggested she gradually resume bearing weight on the left foot, she was still limping on June 12, 2007 and asked to see a foot specialist. Dr. Sheth referred her to Dr. Perns, a podiatrist, who placed her in a wrap and performed a number of injections. On June 27, 2007, Dr. Sheth described Petitioner as "still dragging her left foot with crutches." Almost a month later, Petitioner was still relying on a cane. While Petitioner's physical therapist noted steady improvement and discharged Petitioner on August 16, 2007, at which point the attention turned to Petitioner's knees, Petitioner was still complaining of her left foot and ankle when she saw Respondent's first Section 12 examiner, Dr. Pinzur, on August 21, 2007. Dr. Pinzur diagnosed neurogenic pain stemming from a crush injury. He also found some of Petitioner's symptoms compatible with reflex sympathetic dystrophy. He did not find Petitioner to be at maximum medical improvement. Instead, he recommended a consultation with a pain management specialist. Petitioner did not see such a specialist until late December 2007, when

she came under the care of Dr. Arayan. Like Dr. Pinzur, Dr. Arayan viewed reflex sympathetic dystrophy (also known as complex regional pain syndrome) as a possible additional diagnosis. He prescribed MRI scans and an EMG. It was after the EMG that Petitioner's back became the focus of attention but Petitioner continued to complain of numbness and tingling in her left foot. Dr. Pinzur re-examined Petitioner on March 3, 2009. While he noted inconsistencies, he also noted subjective pain complaints relative to the left foot and ankle. He found it "very difficult to separate out" Petitioner's foot complaints from her back complaints. RX 2 at 16. In June of 2009, Dr. Ghanayem found that the work accident resulted in a crushing injury to Petitioner's left lower leg. Like Drs. Pinzur and Arayan, he found some of Petitioner's symptoms compatible with complex regional pain syndrome.

Based on the mechanism of injury, the treatment records and the opinions of Drs. Perns, Arayan, Pinzur and Ghanayem, the Arbitrator finds that Petitioner's undisputed work accident resulted in a crushing injury involving the left foot and ankle. While Petitioner described her left foot and ankle condition as "better," she did not indicate this condition has fully resolved.

The Arbitrator also finds that Petitioner established causation as to a left knee condition of ill-being that ultimately required surgery in August of 2008. In so finding, the Arbitrator relies in part on the mechanism of injury, with Petitioner being struck by a moving vehicle and falling onto a stony surface. Dr. Maday noted that Petitioner twisted when she fell and Dr. Newman noted that Petitioner landed in an awkward position. The Arbitrator also relies on the fact that Petitioner complained of her left knee on the day of the accident. The Emergency Room records reflect that Petitioner complained of pain in her left leg "from foot to knee." Dr. Sheth also noted complaints relative to the left knee two days after the accident, although he focused primarily on the left foot and ankle. Petitioner testified that she began noticing "popping" in her left knee thereafter but that her foot and ankle condition took precedent. The Arbitrator finds this testimony credible. The Arbitrator also notes that, in June and July of 2007, Petitioner was relying on devices (first crutches and then a cane) to walk and thus was likely not "testing" her left knee to the extent she would have been had she been fully weight bearing. The Arbitrator notes that it was in early August 2007, when Petitioner was increasing her activity level, that knee problems were documented. To be sure, those problems were described as bilateral, with Petitioner's therapist initially mentioning the "rt," or right knee, and later mentioning the "lt," or left, knee. Those problems were also linked with stair usage, with the therapist noting Petitioner's knees were giving way when she climbed up stairs. When Petitioner was confronted with the therapy notes under cross-examination, she acknowledged the "giving way" with stair usage but denied any fall or other specific trauma after the initial work accident. The Arbitrator finds this denial credible. The Arbitrator acknowledges that, on August 22, 2007, when Petitioner first sought an orthopedic consultation with Dr. Maday specifically for her knee problems, the doctor described her right knee as more symptomatic than her left. However, it was only the left knee that was found to have meniscal pathology on MRI. The right knee MRI showed no such pathology. Petitioner, perhaps inadvertently, claimed some medical expenses relative to the right knee, but is not claiming any current right knee condition of ill-being.

In analyzing causation with respect to the left knee, the Arbitrator also notes that Petitioner's initial care was overseen by a medical case manager and that this manager, whose name was apparently Pat Galvin, gave the go-ahead for the visit to Dr. Maday. Dr. Maday was not a physician of Petitioner's selection. Rather, he was a partner of Dr. Perns, to whom Petitioner was referred by MercyWorks, the occupational health clinic. While authorization of care is not an admission of liability, the Arbitrator finds it significant that Respondent facilitated knee-related treatment in August of 2007. Respondent did later seek out a Section 12 opinion from Dr. Mercier regarding the knee condition (see Exhibit A attached to RX 8) but the Arbitrator assigns no weight to this opinion. The Arbitrator notes that, when Dr. Mercier examined Petitioner's left knee, he documented pain to palpation over the mid medial joint line. The Arbitrator also notes that Dr. Pinzur, who specializes in lower extremity injuries, elected to stay silent on the issue of whether the work accident resulted in a left knee condition. RX 2 at 23-25. In finding causation as to the left knee, the Arbitrator relies on Dr. Maday's and Dr. Newman's opinions. Of these two opinions, the Arbitrator relies predominantly on that of Dr. Newman since Dr. Newman reviewed the earliest treatment records and had a better grasp of the chronology. PX 6.

The Arbitrator also finds that Petitioner established causation as to her lower back and left leg condition of ill-being. While Petitioner was involved in a motor vehicle accident on December 17, 2008, and reported an increase in back pain thereafter, Dr. Cerullo had recommended a discogram a month before that accident. PX 2. Based on the December 29, 2008 Emergency Room records, which reflect an "exacerbation of chronic pain" rather than any acute neurologic injury, along with Dr. Newman's note of January 29, 2009, which supports Petitioner's testimony that she recovered from the motor vehicle accident after a period of rest, the Arbitrator finds that the motor vehicle accident caused only a temporary worsening of Petitioner's work-related lumbar spine condition. See, e.g., Vogel v. Industrial Commission, 354 Ill.App.3d 780, 789 (2nd Dist. 2005). Dr. Mercier diagnosed an acute lumbar strain on October 25, 2007. RX 8, Exh A. Dr. Pinzur described Petitioner's March 3, 2009 back examination as abnormal (RX 2 at 13, 15, 20, 23-25). He limited his return-to-work opinions to Petitioner's foot and ankle condition. RX 2 at 16. Dr. Ghanayem found causation as to a lumbar spine condition, albeit not the same condition Drs. Cerullo and Onibokun diagnosed. The Arbitrator relies primarily on the objective testing and the testimony of Dr. Cerullo in finding that Petitioner established causation as to a surgical lumbar spine condition of ill-being.

Is Petitioner entitled to reasonable and necessary medical expenses?

Having found that Petitioner established causation as to her left foot and ankle, left knee and lower back/left leg conditions of ill-being, the Arbitrator further finds that the treatment Petitioner underwent for these conditions was reasonable and necessary. Respondent's examiners took no issue with the treatment rendered prior to their respective examinations. Dr. Ghanayem advised against the recommended spinal fusion. Petitioner decided to forego this surgery, as was her right.

14IWCC0033

Petitioner claims the following medical expenses:

Provider	Date(s) of Service	Total Original Charges	Fee Sched. Amt. Due
Advocate Lutheran General	3/31/08-Dr. Noren	$ 210.00	$ 210.00
AMIC	9/10/07-knee MRIs	$ 2,790.00	$ 2,353.30
Chicago Central EP	5/15/07-ER phys.	$ 235.00	$ 196.11
CINN (Dr. Cerullo)	10/1/08-4/13/09	$ 781.00	$ 606.29
Dr. Pavlovic	10/4/07 (LS X-rays)	$ 43.00	$ 43.00
Health Benefits	12/27/07-10/2/12 (EMG, injections and discogram)	$ 35,833.30	$ 27,094.42
Illinois Bone and Joint (Dr. Newman)	7/1/08-4/9/09	$ 14,603.00	$ 8,218.33
Illinois Pharmacy Management	3/11/08-10/2/12	$ 26,067.80	$ 26,067.80
Illinois Physicians Network	3/15/08-10/2/12	$ 19,643.66	$ 14,486.02
Injured Workers Pharmacy	3/3/10-7/21/10	$ 1,256.57	$ 866.79
Jackson Park Hosp.	3/31/08-5/29/08	$ 13,286.92	$ 8,872.95
Lincoln Park Anesthesia	8/15/08-L knee surg.	$ 900.00	$ 885.78
McHenry Laboratory Services	4/28/08-5/29/08	$ 42.00	$ 42.00
Midland Orthopedic	5/28/08-Dr. Sheth	$ 96.98	$ 96.98
Radiological Physic.	5/17/07-X-rays	$ 59.00	$ 59.00
St. Joseph Hospital	8/7/08-8/15/08 (pre-op and left knee surgery)	$ 7,955.50	$ 6,034.19
The Friedell Clinic	5/1/08-5/29/08 (lumbar injections)	$ 1,104.00	$ 1,104.00
Total Rehab	7/10/08-11/18/08 & 3/31/09-4/16/09	$ 9,262.40 (total for both therapy periods)	$ 8,979.01
Universal Radiology	12/17/08 (X-rays of chest, neck, pelvis, etc.)	$ 164.00	$ 164.00
	TOTAL:	$ 134,334.13	TOTAL: $ 106,379.97

PX 31. The fee schedule amounts listed above are based on a stipulation submitted by the parties after the hearing. The stipulation provides that, if the Arbitrator awards the foregoing bills, the fee schedule amount owed is the amount stated in the right hand column on the preceding page.

The Arbitrator, having reviewed the bills in PX 31, the treatment records and the arguments set forth in Respondent's proposed decision, declines to award the bills from Advocate Lutheran General Hospital, Dr. Pavlovic and Universal Radiology. The bills from Advocate Lutheran General Hospital and Dr. Pavlovic are not supported by any treatment records. The bill from Universal Radiology stems from Emergency Room treatment Petitioner underwent following her motor vehicle accident of December 17, 2008. With respect to the bill from AMIC [Advanced Medical Imaging Center], for bilateral knee MRIs performed on September 10, 2007, the Arbitrator awards only the charges relating to the left knee MRI. A collection letter in PX 31 reflects that those charges totaled $1,395.00 and that workers' compensation paid $613.95 toward those charges. The parties have stipulated that the fee schedule charges for bilateral knee MRIs total $2,353.30. Fifty percent of this amount is $1,176.65. Thus, with respect to the AMIC charges, the Arbitrator awards $1,176.65, with Respondent receiving credit for the $613.95 it paid. With respect to the bill from Total Rehab, the Arbitrator awards only the charges stemming from therapy performed between July 10, 2008 and November 18, 2008. The Arbitrator declines to award the charges relating to the therapy Petitioner underwent at Total Rehab from March 31, 2009 through April 16, 2009. Petitioner offered into evidence only those records from Total Rehab that relate to the therapy she underwent in 2008. PX 14.

While Petitioner claims an outstanding balance of $96.98 from Midland Orthopedic Associates (Dr. Sheth), the bill from that facility shows a zero balance. Accordingly, the Arbitrator awards no expenses associated with the care rendered by Midland Orthopedic Associates.

Subject to the exceptions discussed in the preceding two paragraphs, the Arbitrator awards the stipulated fee schedule charges enumerated in the right hand column on the preceding page.

Is Petitioner entitled to temporary total disability and/or maintenance?

At the hearing, Petitioner claimed temporary total disability benefits running from May 16, 2007 through January 31, 2010 while Respondent claimed benefits running from May 16, 2007 through October 1, 2007. The parties agreed Respondent paid benefits totaling $93,417.31 prior to hearing. Arb Exh 1. In her proposed decision, Petitioner clarified that she is seeking temporary total disability benefits through August 31, 2009, the date on which Dr. Rosania imposed permanent restrictions per the functional capacity evaluation, and maintenance thereafter through January 31, 2010, shortly before she resumed working for Chicago Public Schools. PX 32.

Based on Petitioner's testimony, the treatment records and Dr. Ghanayem's opinions, and in reliance on Interstate Scaffolding, Inc. v. IWCC, 236 Ill.2d 132 (2010), the Arbitrator finds that Petitioner was temporarily totally disabled from May 16, 2007 through August 31, 2009, a period of 119 6/7 weeks. On May 15, 2007, the date of the accident, Petitioner was discharged from the Emergency Room with a boot, crutches and instructions to remain off work. Dr. Sheth of MercyWorks continued to keep Petitioner off work thereafter. Dr. Sheth subsequently referred Petitioner to Dr. Perns, who treated Petitioner's left foot and ankle condition. On August 20, 2007, Dr. Perns released Petitioner to work as of September 4, 2007. On August 21, 2007, Respondent's examiner, Dr. Pinzur, recommended a consultation with a pain management specialist and found Petitioner capable of only sedentary to sedentary-light duty. RX 2. The recommended consultation did not take place at that time. On August 22, 2007, Dr. Perns' partner, Dr. Maday, addressed Petitioner's knee problems and recommended MRIs. The left knee MRI demonstrated a meniscal tear, which Dr. Maday linked to the work accident. On September 12, 2007, Dr. Maday recommended a meniscal repair. On October 1, 2007, Dr. Perns released Petitioner from care with respect to her foot and ankle but noted Petitioner was still seeing Dr. Maday for her knee problems. On November 19, 2007, Dr. Perns wrote out a slip indicating Petitioner could return to work as of October 2, 2007 but, again, that was a release relative to the foot. The meniscal tear had not yet been repaired. On December 3, 2007, Dr. Perns recommended EMG/NCV testing. Dr. Arayan performed this testing on December 27, 2007. PX 1. Petitioner followed up with Dr. Arayan on March 6, 2008 and reported having been off work since the May 15, 2007 accident. Dr. Arayan began to treat Petitioner's back and leg complaints and also noted Petitioner might need a meniscal repair. Petitioner subsequently saw Dr. Newman for her left knee and he performed the meniscal repair on August 15, 2008. Petitioner saw Dr. Cerullo for her back and leg pain on October 1, 2008. Dr. Newman found Petitioner to be at maximum medical improvement with respect to her left knee on October 13, 2008 but noted Petitioner needed to remain off work with respect to her back condition. Dr. Cerullo continued treating Petitioner's back thereafter. Following a concordant discogram, he referred Petitioner to Dr. Onibokun, who found Petitioner to be a surgical candidate. On June 19, 2009, Respondent's examiner, Dr. Ghanayem, opined that Petitioner would not benefit from surgery. It is at this point that Respondent stopped paying temporary total disability benefits. The Arbitrator notes, however, that, while Dr. Ghanayem did not recommend spinal surgery, he did recommend back-related therapy and ongoing pain management for Petitioner's left leg condition. He did not find Petitioner capable of resuming her former trade. In the Arbitrator's view, Petitioner did not reach maximum medical improvement until August 31, 2009, at which point Dr. Rosania (Dr. Arayan's replacement) imposed permanent restrictions in accordance with the valid July 27, 2009 functional capacity evaluation. PX 3.

Based on Petitioner's testimony and the job search records in PX 20, the Arbitrator further finds that Petitioner is entitled to maintenance from September 1, 2009 through January 31, 2010, a period of 21 6/7 weeks. Petitioner testified she performed a self-directed search for employment during this period. The records in PX 20 support this testimony. Petitioner had no alternative but to look for work on her own since Respondent did not 1) offer Petitioner restricted duty; 2) complete a written assessment, as required by Rule 7110.10 of the

Rules Governing Practice Before the Workers' Compensation Commission; or 3) provide vocational assistance. Even after the valid functional capacity evaluation of July 27, 2009 confirmed Dr. Ghanayem's opinion that Petitioner would be unable to resume her former trade, Respondent took no action other than to retain Julie Bose, who confined her activities to performing a labor market survey.

(cont'd next page)

Is Petitioner entitled to wage differential benefits?

Petitioner seeks wage differential benefits in the amount of $693.03 per week from February 1, 2010 through May 31, 2012 and in the amount of $706.39 per week from June 1, 2012 forward and for the duration of her disability. Respondent, in reliance on its causation defenses, the opinions expressed by Julie Bose and the union document marked as RX 13, maintains that Petitioner is not entitled to a wage differential award. Respondent argues, in the alternative, in favor of a permanency award under either Section 8(e) or Section 8(d)(2).

Section 8(d)1 of the Act provides, in relevant part:

> "If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall . . . receive compensation for the duration of his disability . . . equal to 66 2/3% of the difference between the average amount he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident."

In the instant case, there is no real dispute that Petitioner is "partially incapacitated" from pursuing her previous trade, i.e., cement masonry, as a result of the work accident of May 15, 2007. RX 1. Respondent's examiner, Dr. Ghanayem, admitted as much and a valid functional capacity evaluation placed Petitioner at a light work demand level. Nor is there any dispute that Petitioner was in the second year of a three-year apprenticeship when the accident occurred. Disputes exist, however, as to whether the employment Petitioner returned to in February of 2010, i.e., substitute teaching, constituted "suitable employment" and whether "full performance" earnings for Petitioner are the earnings of an apprentice or a journeyman.

The Arbitrator has carefully considered Petitioner's testimony as well as the earnings records in PX 31 and the opinions of Susan Entenberg and Julie Bose. Petitioner clearly took pleasure and pride in the work she performed for Chicago Public Schools between February of 2010 and June 2012. Although Petitioner was classified as a "substitute," it appears her job performance was such that one particular high school began to give her assignments on a very regular basis. Entenberg found substitute teaching to be "suitable employment" for Petitioner. Bose agreed that substitute teaching met Petitioner's needs and fit well with her pre-accident work background. Nevertheless, she opined that Petitioner was "under-employed" as a substitute teacher. She recommended that Petitioner return to school to obtain her teaching certificate. The Arbitrator notes, however, that there is no evidence Respondent offered to pay for any additional schooling. The Arbitrator also notes that some of the grades Petitioner received in writing-related courses at Columbia College call Bose's certification

recommendation into question.

Bose also found Petitioner capable of working in other capacities and earning a very significant starting wage. Entenberg agreed that Petitioner was not limited to substitute teaching but opined that Petitioner would not earn much more if she changed occupations.

The Arbitrator places no stock in Bose's opinion that Petitioner could secure work in a management position in sales, insurance or marketing and start out earning $31.30 or more per hour. Bose never met with Petitioner and did not have an accurate understanding of her actual work history or her very limited experience with the insurance industry.

The Arbitrator elects to rely on Bose's and Entenberg's shared opinion that Petitioner could work as an administrative assistant and that the mean starting wage for such work is $17.60 per hour, or $704.00 per week. The Arbitrator views such an occupation and wage as realistic for Petitioner. The Arbitrator acknowledges that a wage of $704.00, paid 52 times per year, exceeds the somewhat irregular earnings Petitioner derived from substitute teaching between 2010 and 2012. Nevertheless, the Arbitrator views this wage and work schedule as more fairly representative of Petitioner's earning capacity. No physician has restricted Petitioner from working year-round.

The Arbitrator next addresses the issue of the average amount Petitioner could be earning in the "full performance" of her former cement mason duties. Petitioner maintains that, by virtue of completing the coursework required of a third-year apprentice and receiving a "Certificate of Completion of Apprenticeship" (PX 21) in 2009, she would have earned $41.85 per hour, or $1,674.00 per week, as a journeyman from February 1, 2010 through May 31, 2012 (PX 27-29) and $42.35 per hour, or $1,694.00 per week, as a journeyman from June 1, 2012 forward and for the duration of her disability. Respondent argues that it would be speculative to award wage differential benefits based on the journeyman wage scale, citing RX 13 and Deichmiller v. Industrial Commission, 147 Ill.App.3d 66 (1st Dist. 1986).

The Arbitrator views the facts of Deichmiller as distinguishable from those of the instant case. Deichmiller involved a claimant who was injured while working for Zonca Plumbing in April of 1980, a year after being admitted to Local 130 a "temporary journeyman plumber." At trial, Zonca's vice president testified that, if the claimant had continued paying union dues, he would have become eligible to sit for a journeyman examination in November 1981 and, based on his skills, would likely have passed the examination. The claimant acknowledged that he never actually took the examination. The Commission found it would be "merely speculation" to assume the claimant would have become a journeyman plumber. The Commission calculated wage differential benefits by "subtracting the average amount which the claimant actually earned after the accident from the amount he would have earned as a fourth-year apprentice plumber." The Circuit Court affirmed, as did the Appellate Court, reasoning as follows:

> "We conclude that the Commission properly determined that It would have been 'mere speculation' to assume that claimant would have become a journeyman plumber. The record indicates that claimant never took the union examination. In fact, claimant did not testify that he ever intended to take the examination. It is axiomatic that liability under the Act cannot be based on speculation or conjecture but must be based solely on the facts contained in the record." [citations omitted]

147 Ill.App.3d at 73-74. In the instant case, in contrast, Petitioner not only finished the required union coursework but also received a Department of Labor document in 2009 certifying she completed her apprenticeship. PX 21. Therefore, the Arbitrator does not have to engage in speculation to conclude that Petitioner would have been paid at a journeyman's rate had she been physically able to resume working as a cement mason in February of 2010.

Based on the foregoing analysis, the Arbitrator awards Petitioner wage differential benefits in the amount of $646.67 per week from February 1, 2010 through May 31, 2012. This amount represents 2/3 of the difference between $1,674.00 and $704.00, or 2/3 of $970.00. The Arbitrator awards Petitioner wage differential benefits in the amount of $660.00 per week beginning June 1, 2012 and continuing for the duration of her disability. This amount represents 2/3 of the difference between $1,694.00 and $704.00, or 2/3 of $990.00.

(cont'd on next page)

Is Respondent liable for penalties and fees?

Petitioner seeks penalties and fees on awarded unpaid medical expenses, awarded unpaid temporary total disability and maintenance and awarded unpaid wage differential benefits.

Initially, the Arbitrator addresses Petitioner's claim for penalties and fees on awarded unpaid medical expenses. A number of those expenses stem from treatment Petitioner underwent for her left knee. On this record, the Arbitrator cannot conclude that Respondent acted unreasonably or vexatiously in disputing causation as to this body part. Petitioner complained of her left leg, "from foot to knee," on the date of the accident but no additional knee complaints were documented for some time thereafter. As for the remaining awarded medical expenses, there is no evidence in the record indicating Petitioner demanded payment of those expenses from Respondent prior to hearing. Petitioner did file several petitions for penalties and fees in 2009 and 2010 (PX 23-26) but those petitions only generally allege non-payment of medical expenses. The petitions do not specifically reference any of the bills enumerated in PX 31. There is evidence, however, indicating that four of the providers whose bills the Arbitrator has awarded, namely Health Benefits Physicians Services (Drs. Arayan, Watson and Rosania), Illinois Pharmacy Management (medication prescribed by Drs. Cerullo and Rosania), Illinois Physicians Network (lumbar spine testing and treatment plus FCE) and Injured Workers Pharmacy (medication prescribed by Dr. Rosania), repeatedly and unsuccessfully billed Respondent's carrier, ESIS, over an extended period beginning in January of 2008. PX 31. The Arbitrator finds that Respondent failed to meet its burden of proving that it acted in an objectively reasonable manner, under all of the existing circumstances, in refusing to pay the bills of these four providers. Dr. Pinzur, who examined Petitioner on behalf of Respondent in August of 2007, recommended a consultation with a pain management specialist. This consultation did not take place until late December 2007, when Petitioner saw Dr. Arayan. In the interim, Dr. Mercier diagnosed Petitioner with an acute lumbar strain. RX 8, Exh A. Dr. Arayan worked up both the foot/ankle complaints and the lumbar spine/radicular complaints. He eventually referred Petitioner to Dr. Cerullo, who went on to refer Petitioner to Dr. Onibokun. Drs. Cerullo and Onibokun recommended surgery following a concordant discogram. Respondent did not obtain a Section 12 examination concerning Petitioner's lumbar spine condition until June 19, 2009. RX 1. While Respondent's spine examiner, Dr. Ghanayem, disagreed with Dr. Cerullo's and Dr. Onibokun's interpretation of the discogram and surgical recommendation, he found causation as to a back condition and did not take issue with any of the back-related treatment rendered to date. RX 1. Dr. Ghanayem was apparently unaware of the intervening motor vehicle accident but, for the reasons previously stated, the Arbitrator does not view this accident as providing Respondent with a valid causation defense. Respondent did not submit any utilization review evidence.

The parties have stipulated that the fee schedule charges of Health Benefits, Illinois Pharmacy Management, Illinois Physicians Network and Injured Workers Pharmacy are $27,094.42, $26,067.80, $14,486.02 and $866.79, respectively. These amounts total

$68,515.03. The Arbitrator awards Section 19(k) penalties in the amount of $34,257.52, representing 50% of $68,515.03. The Arbitrator awards Section 16 attorney fees in the amount of $13,703.01, representing 20% of $68,515.03. The Arbitrator awards Section 19(l) penalties at the rate of $30.00 per day and in the statutory maximum amount of $10,000.00 based on the substantial delay in payment since the early part of 2008.

The Arbitrator also awards penalties and fees on the unpaid portion of the awarded temporary total disability and maintenance benefits. Those benefits total $125,275.43 ($884/week x 141 5/7 weeks) with Respondent receiving a stipulated credit for the $93,417.31. Arb Exh 1. in benefits it paid prior to hearing. The awarded unpaid balance equals $31,858.12. Respondent discontinued the payment of temporary total disability benefits as of Dr. Ghanayem's Section 12 examination of June 19, 2009, despite the fact that Dr. Ghanayem found causation as to a back condition, indicated more back therapy might be needed and opined that Petitioner would likely be unable to resume cement masonry, pending a functional capacity evaluation. RX 1. Respondent did not reconsider its position even after a valid functional capacity evaluation performed on July 27, 2009 showed that Petitioner was capable of only light physical demand work. PX 3. As discussed earlier, Respondent never prepared a written assessment in accordance with the Rules and failed to provide vocational rehabilitation. The Arbitrator awards Section 19(k) penalties in the amount of $15,929.06, representing 50% of $31,858.12, and Section 16 attorney fees in the amount of $6,371.62, representing 20% of $31,858.12. The Arbitrator has already awarded the maximum penalty under Section 19(l).

The Arbitrator declines to award penalties or fees on the awarded wage differential benefits. While there is no dispute that Petitioner's work accident prevented her from resuming her former trade, and while the Arbitrator does not agree with many of the opinions expressed by Respondent's vocational consultant, Julie Bose, the task of determining the appropriate wage differential benefit in this case has been daunting, both in terms of the "full performance" analysis and the "suitable post-accident employment" analysis. Given the limited information transmitted to Respondent via PX 26 (the petition seeking penalties and fees based on wage loss), the widely varying amounts Petitioner received from Chicago Public Schools after January 31, 2010, the debate as to the requirements of apprenticeship completion, the conflicting opinions of Entenberg and Bose and representations set forth in RX 8 [Respondent's Response to Petitioner's penalties/fee petition(s)], the Arbitrator finds that a valid controversy existed as to the amount of the benefit that was due.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
SANGAMON		☐ PTD/Fatal denied
	☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAVERNE WILLIAMS,

Petitioner,

vs.

NO: 08 WC 24676

14IWCC0034

CHAMPAIGN COUNTY NURSING HOME,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

We modify the Arbitrator's award of temporary total disability benefits. In the Arbitrator's order, he awarded temporary total disability benefits for 235-5/7 weeks. However, the time period from May 11, 2008, through November 21, 2012, is 236-4/7 weeks. Further, in the body of his decision, the Arbitrator stated that Petitioner is entitled to temporary total disability benefits beginning March 11, 2008. We clarify that Petitioner is entitled to and awarded temporary total disability benefits beginning May 11, 2008, through November 21, 2012, for a period of 236-4/7 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

14IWCC0034

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $281.78 per week for a period of 236-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $441.93 per week for life, beginning November 22, 2012, as provided in §8(f) of the Act, for the reason that the injuries sustained caused Petitioner to become permanently and totally disabled.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $91,427.68 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
TJT: kg
O: 11/25/13
51

Thomas J. Tyrrell

Daniel R. Donohoo

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, LAVERNE
Employee/Petitioner

Case# **08WC024676**

CHAMPAIGN COUNTY NURSING HOME
Employer/Respondent

14IWCC0034

On 3/6/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2934 JOHN V BOSHARDY & ASSOCIATES
1610 S SIXTH ST
SPRINGFIELD, IL 62703

0522 THOMAS MAMER & HAUGHEY LLP
BRUCE E WARREN
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61820

14IWCC0034

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☒ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Laverne Williams
Employee/Petitioner

v.

Champaign County Nursing Home
Employer/Respondent

Case # 08 WC 24676

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **February 4, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD

L. ☒ What is the nature and extent of the injury?

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

14IWCC0034

FINDINGS

On **May 10, 2008** , Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $ **21,973.64** ; the average weekly wage was $ **422.57** .

On the date of accident, Petitioner was **49** years of age, *single* with **1** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit for $**51,512.69** for TTD, $_____ for TPD, $_____ for maintenance, and $_____ for other benefits, for a total credit of $**51,512.69**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total/ maintenance disability benefits of $ **281.78**/week for **235 & 5/7** weeks, commencing **May 11, 2008** through **November 21, 2012** , as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner $ **441.93**/week beginning **November 22, 2012** for **life** , because the injuries sustained caused **Petitioner to become permanently and totally disabled** as provided in Section 8(f) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **May 10, 2008** through **February 4, 2013** , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay **$ 91,427.68,** for medical services, as provided in Section 8(a) of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dyla McCarthy
Signature of arbitrator

Feb. 27, 2013
Date

MAR 6 - 2013

IN support of the Arbitrator's findings on the issue of **(F) Is the Petitioner's present condition of ill-being causally related to the injury?,** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner and Respondent stipulated that Petitioner sustained an accidental injury which arose out of and occurred in the course of her employment on May 10, 2008. On that date, the Petitioner was employed as a Certified Nurses Assistant (CNA) and had been so employed by the Respondent since January of 2006. On May 10, 2008, Petitioner and another nurse came to the aid of another CNA who was in the process of lifting a resident using a Hoyer lift. The resident was stuck in the air and was falling out of the Hoyer lift. Petitioner and the other nurse grabbed a hold of the resident. Petitioner stated that she used both arms to grab the resident around the waist. The other nurse complained that she had a problem with her back and let the resident go. Petitioner supported the full weight of the resident and tried to ease the resident into the bed. The bed was not secured and rolled away and the resident fell forward pulling the Petitioner with her. The Petitioner estimated the resident to weigh approximately 260 pounds.

Petitioner felt immediate neck pain that went to the right shoulder and up her head, back pain, and numbness in her arms. Petitioner notified her supervisor and was sent to Provena Covenant Medical Center. (P.X. 3) The emergency room records note the accident as described above and that the Petitioner complained of pain on the right side of her neck and going all the way down her back. (P.X.3) Petitioner was diagnosed with a cervical and lumbar sprain, given medications, removed from work, and advised to follow-up with occupational medicine. (P.X.3)

Petitioner was seen at the Department of Occupational Medicine-Workers' Compensation of Carl Clinic in Urbana, Illinois. (P.X.4) Petitioner was first examined by Dr. Philbert Chen on May 12, 2008 at which time the Petitioner again advised the doctor of the work accident. (P.X.4) On examination, Dr. Chen noted pain over the right trapezius, neck pain to the right, and tenderness in the lumbar spine. (P.X. 4) Dr. Chen issued light duty work restrictions, ordered a TENS unit, and referred the Petitioner to physical therapy. (P.X.4)

On May 16, 2008 Petitioner returned to Dr. Walter MacGuire, who was filling in for Dr. Chen, who noted that the "pain is still in the neck and right shoulder." (P.X.4) The treatment plan remained the same. (P.X.4) Petitioner underwent extensive physical therapy at Carle Clinic Physical Therapy beginning on May 19, 2008. (P.X.5)

On May 27, 2008 the Petitioner returned to Dr. Chen and noted the Petitioner was not improving and was still having "...pain in the neck and the right shoulder area...with radicular pains down the right arm." (P.X.4) Dr. Chen diagnosed the Petitioner with a right sided cervical strain and ordered an MRI. (P.X.4)

The MRI of the cervical spine was taken on June 10, 2008 and showed a disk protrusion at C2-3, C3-4, and C5-6 disk protrusions which effaced the thecal sac causing mild canal stenosis, and C6-7 central disk osteophyte complex causing asymmetric moderate spinal canal stenosis. (P.X.4)

On June 11, 2008 Petitioner reported to Dr. Chen that her physical therapy would help for a couple of hours but the pain would return. (P.X.4)

Petitioner reported to Dr. Chen on June 11, 2008 that she had constant pain from below both of her elbows extending to both shoulders, shooting pain from the posterior neck to the upper paraspinal and upper chest area and both shoulders. (P.X.4) On examination, Dr. Chen noted tenderness over both shoulders, mostly below the acromium. (P.X.4) Dr. Chen referred the Petitioner to Dr. Hurford of the Spine Institute for further evaluation. (P.X.4)

Petitioner was seen by Dr. Hurford on June 20, 2008, noting the Petitioner's work accident and that she had neck pain, trapezial pain, some shoulder pain, low back pain, and right thigh pain. (P.X.4) Dr. Hurford reviewed the MRI study and examined the Petitioner. (P.X.4) Dr. Hurford did not recommend surgery but noted she should continue doing therapy for neck and back pain. Dr. Hurford also suggested a right shoulder evaluation. (P.X.4)

Petitioner returned to Dr. Thomas Sutter, who is also with Carle Clinic Department of Occupational Medicine, where he noted that Petitioner had continued low back pain, some neck soreness, and right shoulder pain. (P.X.4) Dr. Sutter reviewed Dr. Hurford's report and ordered a right shoulder MRI. (P.X.4)

The MRI was taken on July 3, 2008 and showed a "tiny rotator cuff tendon tear near the insertion. (P.X.4)

Dr. Chen reviewed the MRI with the Petitioner on July 10, 2008 and noted that any movement to abduct the right arm increased the Petitioner's pain and Petitioner had impingement symptoms. (P.X.4) Dr. Chen added "right shoulder injury, to rule out rotator cuff tear" to Petitioner's diagnosis of cervical low back strain. (P.X.4)

Dr. Chen referred the Petitioner to aqua therapy for her neck and low back and to orthopedics. Dr. Chen also stated that he would consider further work-up for Petitioner's lower back strain depending on her symptomology. (P.X.4)

Petitioner was seen by Dr. Robert Gurtler on July 29, 2008 at which time he was advised of the work accident, reviewed the MRI, and noted the Petitioner's complaints of right shoulder and neck pain. On this date the Petitioner advised Dr. Gurtler that she had no symptoms with her left shoulder. Dr. Gurtler recommended an arthrogram to determine the extent of the rotator cuff tear. The arthrogram was performed on August 5, 2008. (P.X. 4)

Dr. Gurtler interpreted the arthrogram as revealing a full thickness rotator cuff tear and recommended rotator cuff repair. (P.X.4)

On September 14, 2008, the Petitioner sought treatment from Carle Hospital complaining of left arm and shoulder pain. (P.X.6) The nursing notes indicate the pain was in the left elbow, however, the admission registration form indicates that the Petitioner was admitted with complaints of left shoulder and arm pain and related the facts of the work accident and her other medical care on the right arm. (P.X.6, p. 12)

Before proceeding with surgery, the Petitioner returned to Dr. Sutter complaining of continued pain in the left elbow and shoulder and requested that her left shoulder be evaluated. (P.X.4) Dr. Sutter asked her to discuss her left elbow and shoulder with Dr. Chen. (P.X.4) Petitioner saw Dr. Chen the next day where he stated that the Petitioner had been noticing increasing discomfort in the left elbow area. (P.X.4) Dr. Chen diagnosed the Petitioner with left lateral epicondylitis. (P.X.4)

Dr. Gurtler performed an open rotator cuff repair, distal clavicle resection, and subacromial decompression on September 19, 2008. (P.X.7) Petitioner stated that after surgery her arm was immobilized and strapped to her waist for two weeks. Petitioner used her left arm and hand for all of her activities. Dr. Gurtler started the Petitioner on passive range of motion exercises on September 30, 2008. (P.X.4)

On October 7, 2008, Petitioner returned to Dr. Chen in follow-up of her right shoulder surgery and advised Dr. Chen that her left shoulder as well as her left elbow had continued to bother her "...but with the increasing limitation on the right side, she has had to do more with the left arm and that has aggravated her symptoms. (P.X.4) Dr. Chen did not examine the right shoulder deferring it due to her sling and recent surgery. Dr. Chen examined the left shoulder and noted discomfort with abduction. (P.X. 4) Dr. Chen noted mild impingement symptoms, as well as tenderness over the AC joint and bicipital tendon with discomfort over the medial epicondyle. (P.X.4) Dr. Chen added the diagnoses of left shoulder impingement and lateral epicondylitis. Dr. Chen was unsure of how the "insurance would view the left shoulder" and referred the Petitioner to Dr. Zimmerman in Orthopedic Sports Medicine for further evaluation. (P.X.4)

Petitioner was seen by PA Danny McFarlin on October 14, 2008, at which time the Petitioner relayed the history of her work accident and her prior treatment to her right shoulder, neck, and back. (P.X.4) PA McFarlin noted that the Petitioner's left shoulder pain had increased since her right shoulder surgery and that she had been receiving physical therapy for her left shoulder. PA McFarlin examined the right shoulder and recommended that the Petitioner begin physical therapy on the right shoulder with passive range of motion for four weeks and thereafter active range of motion. (P.X.4) On examination of the left shoulder PA McFarlin noted a strongly positive impingement sign and pain on palpation of the shoulder joint. PA McFarlin deferred further treatment of the shoulder "...due to the fact that Worker's Compensation is involved." (P.X.4)

On October 24, 2008, Dr. Chen noted the Petitioner's course of treatment with her left elbow pain from before the surgery, her continued left shoulder symptoms, and that Petitioner's request for treatment of the left shoulder had been denied by the insurer. (P.X.4) Dr. Chen noted that the Petitioner was convinced that the left

shoulder was related to the work accident, and did have health insurance, but that she wanted to let it lapse. (P.X.4) Dr. Chen suggested an Independent Medical Examination and advised her to pursue treatment of her left shoulder using her health insurance if the same was not approved by workers' compensation. (P.X.4)

On November 4, 2008, Dr. Chen referred the Petitioner to Dr. Zimmerman for further treatment of her left shoulder. (P.X.4)

Petitioner was seen by Dr. Jerrad Zimmerman for left elbow and shoulder pain on December 1, 2008. (P.X.4) Dr. Zimmerman examined the Petitioner and diagnosed her with left lateral epicondylitis and left shoulder impingement. Dr. Zimmerman injected the Petitioner's left shoulder with a corticosteroid. (P.X.4) Petitioner returned to PA McFarlin on January 2, 2009 for her right shoulder noting worsening symptoms recently without any new injury. PA McFarlane administered a corticosteroid injection into the subacromial space of the right shoulder. (P.X.4)

Dr. Zimmerman noted improvement in the left shoulder that he had injected on January 7, 2009 and released the Petitioner to return on an as needed basis. (P.X.4)

On January 12, 2009, Dr. Chen entered a clarification note in his records documenting that the right shoulder injury was a non disputed workers' compensation claim. Dr. Chen also noted that the Petitioner had been seen for left shoulder impingement and tendonitis and stated that any previous notes suggesting that the left shoulder was not related to the workers' compensation injury did not represent his opinion regarding whether the left shoulder was related to Petitioner's original work accident. (P.X.4) Dr. Chen went on to state that it "...would be reasonable to have those symptoms come on either as a result of the original injury or secondarily to overcompensation using the left side because of the inability to do activities on the right side. (P.X.4)

It was noted on January 30, 2009 that Petitioner continued to experience right shoulder pain and had decreased range of motion in all planes. (P.X.4) Petitioner was referred back to Dr. Gurtler for further evaluation. (P.X.4) Dr. Gurtler ordered another arthrogram. (P.X.4)

On February 12, 2009 Dr. Chen referred Petitioner back to Dr. Zimmerman for continued elbow pain. (P.X.4)

A right shoulder arthrogram performed on February 18, 2009 revealed a small, full thickness rotator cuff tear with extension of contrast outside the joint space. (P.X.4)

Petitioner was seen by Dr. Zimmerman on February 23, 2009, where it was noted that Petitioner returned due to left epicondylitis pain, had a recent right shoulder arthrogram showing a recurrent tear, and that she was having more pain in the left shoulder as her right arm was causing her more difficulties. (P.X.4) Dr. Zimmerman injected the Petitioner's lateral epicondyle. (P.X.4)

Dr. Gurtler reviewed the arthrogram results on March 3, 2009 and admitted that he did not completely seal the tear in the previous surgery. (P.X.4) Dr. Gurtler recommended a second repair of the right shoulder and after obtaining workers' compensation authorization Petitioner underwent an arthroscopic rotator cuff repair with fibrin clot reinforcement, a stem cell therapy on April 10, 2009. (P.X.4) Dr. Gurtler's operative report notes that he had some difficulty finding the Petitioner's rotator cuff intra-operatively, and had to review the arthrogram again to locate the tear. On further palpation Dr. Gurtler found the "weak" area and over-sewed the area and sewed in two fibrin clots. (P.X .4, P.X.8)

Petitioner continued with physical therapy at Carle Therapy Services. (P.X.5) Petitioner received follow up care from Dr. Gurtler and Dr. Chen through July and August of 2009. (P.X.4)

On September 10, 2009, Dr. Chen noted the Petitioner had worsening left epicondyle symptoms and that she had three injections into the left lateral epicondyle and referred her back to Dr. Zimmerman for evaluation of her left elbow. (P.X.4)

On September 25, 2009, PA McFarlin noted the Petitioner continued to experience left shoulder pain as well. (P.X.4)

Dr. Zimmerman evaluated the Petitioner on September 28, 2009 and noted she had left lateral epicondyle problems and "...had no other current issues or concerns." Dr. Zimmerman examined only the left elbow and injected the left lateral condoyle. (P.X.4)

On October 30, 2009, Petitioner returned to Dr. Thomas Sutter for continued right shoulder pain. Dr. Sutter injected the right shoulder with a cortico steroid. A third arthrogram of the right shoulder was ordered by Dr. Gurtler on November 10, 2009 and was performed on December 8, 2009. The arthrogram showed extensive post-operative changes along the anterior and superior aspect of the shoulder, particularly within the deltoid and supraspinatous. A "tiny" defect was noted in the supraspinatous tendon measuring 2mm in size. (P.X.4)

Dr. Gurtler viewed the arthrogram, noted its findings but did not think that further surgery was warranted. Dr. Gurtler referred the Petitioner back to Occupational Medicine for return to work issues. (P.X. 4)

On December 15, 2009, work hardening was ordered to be followed by a functional capacity evaluation. (P.X.4) Petitioner had a functional capacity evaluation (FCE) performed on January 11, 2010. (P.X. 9) The FCE noted pain in Petitioner's bilateral upper extremities, which was part of the reason for limitations of lifting from floor to waist. The FCE declared Petitioner gave consistent performance and a good faith effort. (P.X.9)

Petitioner was released by Dr. Chen with permanent restrictions of no lifting over 20 pounds, handle 10 to 15 pounds on an occasional basis, and most of her activities should be below shoulder level. (P.X.4) Dr. Chen noted that her permanent restrictions would not allow her to return to her previous occupation. (P.X.4)

On January 20, 2010, the Petitioner slipped on some ice and fell, injuring her neck and lower back. (P.X.10) On January 27, 2010, Petitioner sought further care for her left elbow with Dr. Zimmerman, who

suggested a fourth injection. (P.X.4) Petitioner returned to Occupational Medicine complaining of right shoulder and left elbow pain. (P.X.4) Further physical therapy was recommended. (P.X.4)

On April 26, 2010, the Petitioner sought treatment from her primary care physician, Dr. M. Lennie Baisa for pain that started from the left side of her neck down her left arm to her elbow. (P.X.11) The Petitioner told Dr. Baisa about the work accident at issue here and her prior medical care for the right shoulder from Occupational Medicine. Petitioner also told Dr. Baisa that she had mentioned her left shoulder symptoms to Occupational Medicine but was told that she had waited too long to address the left shoulder. (P.X.11) Petitioner advised Dr. Baisa that since her right shoulder hurt more than the left she did not complain about the left shoulder as often. (P.X.11)

Dr. Baisa examined the Petitioner and diagnosed Petitioner with neck, shoulder, and upper arm pain and felt the symptoms could be related to cervical radiculopathy and lateral epicondylitis or a rotator cuff tear. (P.X.11) Dr. Baisa recommended C-spine, left shoulder, and elbow x-rays. (P.X.11)

On April 27, 2010, Petitioner saw Dr. Chen for continued complaints of right shoulder and left elbow pain. Dr. Chen suggested that Petitioner have imaging studies done on her left elbow if workers' compensation would approve it and also noted the Petitioner's efforts at obtaining further medical care from her family doctor. (P.X.4)

On May 14, 2010, Dr. Baisa re-evaluated the Petitioner and noted that the cervical spine x-ray showed degenerative disk disease. Dr. Baisa ordered an MRI of the left shoulder. (P.X.11)

MRI of the left shoulder performed on May 19, 2010 revealed moderate left acromioclavicular arthritis. (P.X. 11)

On May 27, 2010 Dr. Chen saw the Petitioner where it was noted that workers' compensation had ceased authorizing further medical care. Dr. Chen suggested that the Petitioner obtain a denial of liability letter from the workers' compensation insurance company and seek further treatment using her health insurance. (P.X.4)

On June 24, 2010 Dr. Baisa interpreted the MRI of May 14, 2010 as showing a partial thickness rotator cuff tear. (P.X. 11) Also on June 24, 2010, Dr. Baisa referenced that she had problems in her right shoulder for which Dr. Gurtler performed surgery in 2009 which were related to a motor vehicle accident. The Arbitrator finds that this notation is a mistake by the doctor as the Petitioner had advised Dr. Baisa of her work accident in her first visit and there is no other mention of any auto accident in any of the records other than the auto accident the Petitioner testified to sustaining four years before the work accident here. (P.X.11)

Dr. Baisa recommended physical therapy on the left and right shoulder which was performed at Christie Clinic beginning July 19, 2010. (P.X.11)

On July 23, 2010, Petitioner advised Dr. Baisa that the physical therapy had not helped and she did not want any further injections. Dr. Baisa referred the Petitioner to Dr. Love for further evaluation of her shoulder.

Dr. Love also noted that she received a history of the work accident catching a falling patient on "May 9, 2008". (P.X.19, p. 6) Dr. Love had no records of her previous treatment. (P.X.19, p. 6-7) Dr. Love examined the Petitioner's left shoulder and noted Petitioner had a positive impingement sign, decreased strength throughout, and good range of motion of her elbow. (P.X.19, p. 6-7) Dr. Love diagnosed the Petitioner with a left shoulder rotator cuff syndrome with a partial rotator cuff tear secondary to impingement. (P.X.19, p. 6-7)
Dr. Love recommended decompression of her shoulder which would include distal clavicle resection, acromioplasty, subacromial bursectomy, and possible rotator cuff repair. (P.X.19, p. 8)

Dr. Love performed the surgery on August 26, 2010. (P.X.16) Dr. Love did not find a rotator cuff tear, just fraying, and made a post-operative diagnosis of acromio-clavicular arthritis with impingement, left rotator cuff syndrome with impingement, and subacromial bursitis. (P.X.19, p. 9) Dr. Love saw Petitioner in follow-up where she noted the Petitioner continued to experience pain in her neck, shoulders, and low back. (P.X.19, p. 11-12) Dr. Love ordered aggressive physical therapy. (P.X.19, p. 13) Petitioner developed a frozen left shoulder and Dr. Love recommended continued aggressive physical therapy. (P.X.19, p. 14)

Dr. Love stated that it was her opinion that impingement arises from overuse and post-traumatic. (P.X.19, p. 17) Dr. Love admitted that she did not have any other details of any car accident history. (P.X.19, p. 20) Dr. Love stated that if the Petitioner caught a falling patient, injured her right shoulder, and had been using her left arm more because of the right shoulder injury, these facts would increase the likelihood that Petitioner would develop left shoulder impingement. (P.X.19, p. 21) It is clear, however, from Dr. Love's testimony that she could not state with any degree of medical certainty that the accident itself could have either caused the left shoulder impingement, or produced an aggravation of any pre-existing condition to that shoulder. (PX 19, p.19-21)

Dr. Love released the Petitioner with a permanent restriction of no lifting over 5 pounds with respect to the left shoulder on July 12, 2011. (P.X.27)

Dr. Stephen Weiss examined the Petitioner at the request of the Respondent on March 3, 2011 and noted that the Petitioner injured her right shoulder, neck, and upper back. (R.X.2) Dr. Weiss was of the opinion that there was no causal relationship between the work accident of May 10, 2008 and the left shoulder condition based on his interpretation of a four month delay between the accident and the onset of any left shoulder complaints, the initial pain diagram which did not show the left shoulder as being symptomatic and the fact that the Petitioner told Dr. Gurtler on July 29, 2008 that her left shoulder was fine. (R.X.2, R.X.1, p. 15)

Dr. Weiss also disagreed with Dr. Love's opinion that Petitioner's overuse of her arm after her right shoulder surgery could have caused her condition to become aggravated. (R.X.3) Dr. Weiss felt that such overuse would not be the case unless the activities that Petitioner was doing were overly provocative such as

overhead activities, overhead lifting on a frequent basis, and were doubling the amount of repetitions. (R.X.1, p. 18)

Dr. Weiss did not consider the medical records concerning Petitioner's right shoulder injury and symptoms immediately after her work accident in assessing work relatedness of the left shoulder impingement Petitioner developed since he examined her only for her left shoulder since the right shoulder was accepted and conceded to be work related. (R.X.1, p. 25-6) Dr. Weiss admitted that he did not note Dr. Chen's record of May 27, 2008 wherein Dr. Chen noted that Petitioner's functional range of motion across the right shoulder was limited. (R.X.1, p. 26-27)

Dr. Weiss also admitted that he did not note or recognize that Dr. Chen stated in his records on June 11, 2008 that Petitioner had tenderness over the right and left shoulder mostly below the acromion because he missed that notation. (R.X.1, p. 27-31) Dr. Weiss admitted that these complaints of pain were well before September of 2008. (R.X.1, p. 31-32)

Dr. Weiss also admitted that he had the record from Dr. Sutter dated September 15, 2008 at which time the Petitioner saw Dr. Sutter and requested that her left elbow and shoulder be more fully worked up and Dr. Sutter referred the Petitioner back to Dr. Chen suggesting that Dr. Chen might want to wait until after the right shoulder surgery and rehabilitation before working on the opposite extremity. (R.X.1, p. 43)

On February 14, 2011 the therapist at the Christie Clinic Department of Physical Therapy obtained a history that Petitioner's back flared up the previous day. (P.X.11) On April 3, 2012 the Petitioner returned to Dr. Baisa complaining of her lower back with radiation down the leg, left more than right. (P.X.11) Petitioner began a course of treatment for the lumbar spine which included epidural steroid injections. (P.X.11)

Petitioner acknowledged that she had been involved in a car accident a few years before this event which caused some lower back problems. She stated that she was not experiencing any lower back problems immediately before the work accident. The Petitioner stated that prior to the work accident here she did not have any injury nor did she have any problem with either of her shoulders.

The Arbitrator notes that there was no evidence the Petitioner had any preexisting problems with either shoulder before May 10, 2008. The Arbitrator finds that the accident of May 10, 2008 caused a right rotator cuff tear, which was treated surgically by Dr. Gurtler on two occasions, and which continues to have radiographic evidence of a tiny supraspinatus defect. (PX 4, 12-9-09 O.V.)

With respect to the left shoulder, the Petitioner first mentioned it to a doctor on June 11, 2008 when treating with Dr. Chen. She was at that time and until September 19, 2008 having substantial functional problems with her dominant right arm as referred to in the office visits referenced above. She again complained about her left shoulder just prior to her right shoulder surgery on September 14, stating that her symptoms increased after her right arm was completely immobilized, as evidenced by her history to Dr. Chen on October

7, 2008. A week later, Dr. Gurtler's P.A. noted strong signs of impingement, and that diagnosis continued through her visit with Dr. Zimmerman on February 23, 2009.

The Respondent argues that her left shoulder complaints basically ended at that time, and as such presumably broke the chain of causation. The Arbitrator does not agree with that argument. While the Petitioner did not seek treatment for the left shoulder after February, she was treating aggressively for her right shoulder, with her second surgery taking place on April 10, 2009. She followed up much as she did with the first surgery, with immobilization followed by therapy, making it perfectly reasonable and logical that she defer her left shoulder care until later that year. She complained about it to her doctors at Carle in September 2009, but it was not treated as she was released from that facility and had to establish care with doctors within the Christie Clinic system. When she finally saw Dr. Love in mid-2010, surgery was performed confirming the condition of shoulder impingement originally diagnosed when her right shoulder was immobilized.

With those facts the Arbitrator concludes that the Petitioner has established, through a timeline of no prior symptoms, an accident which caused serious injuries to a dominant arm, and impingement after periods of obvious overuse, a causal relationship with the left shoulder. The Arbitrator rejects Dr. Weiss' theory that overuse must involve extra repetitive overhead activity when the facts show the Petitioner could not use her right arm at all immediately before and after her first surgery.

The Arbitrator finds that the accident caused an aggravation to a preexisting cervical degenerative disk disease and lumbar spine strain. The Arbitrator further finds that the Petitioner's cervical and lumbar spine conditions after January 20, 2010 are not causally related to the work accident as she did not seek medical care for same until after she sustained an intervening accident on January 20, 2010 when she slipped and fell. Further, there is no medical opinion connecting her work accident of May 10, 2008 to the medical care she subsequently received to her lumbar spine after April 3, 2012.

ATTACHMENT J

In support of the Arbitrator's findings on the issue of **(J) Were the medical services that were provided to the Petitioner reasonable and necessary?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The Arbitrator finds the medical treatment related to the neck and lumbar spine is causally related to the work accident through January 20, 2010. All treatment related to the cervical and lumbar spine thereafter is related to either an underlying preexisting degenerative disk disease, or a fall that occurred on January 20, 2010. (P.X.10)

The Arbitrator finds that medical expenses related to the right and left shoulder, and left elbow, are causally related to the work accident at issue here and orders Respondent to pay the medical expenses related to same pursuant to the Fee Schedule and shall further hold Petitioner harmless from any subrogation claims made by any 8(j) health care insurer for payment of said expenses. Respondent is ordered to pay the related medical expenses follows:

Provena Covenant Medical Center, 5/10/08	$ 3,257.80
Lakeland Radiologists, 5/10/08	$ 155.00
Carle Clinic, 7/3/08-5/27/10	$ 3,196.80
Carle Hospital, 5/19/08-5/30/08	$ 1,182.50
Carle Hospital, 6/2/08-6/20/08	$ 1,399.00
Carle Hospital, 7/15/08-7/31/08	$ 1,196.00
Carle Hospital, 8/5/08	$ 196.00
Carle Hospital, 10/7/08-10/30/08	$ 2,162.00
Carle Hospital, 11/4/08-11/25/08	$ 2,984.00
Carle Hospital, 11/5/08-11/25/08	$ 1,529.00
Carle Hospital, 12/2/08-12/30/08	$ 2,456.00
Carle Hospital, 5/7/09-5/28/09	$ 2,074.00
Carle Hospital, 6/1/09-6/25/09	$ 2,050.00
Carle Hospital, 7/8/09-7/30/09	$ 1,416.57
Carle Hospital, 8/4/09-8/27/09	$ 1,260.00
Carle Hospital, 9/1/09-9/29/09	$ 1,470.00
Carle Hospital, 10/1/09-4/19/11	$ 1,890.00
Carle Hospital, 11/3/09	$ 185.00
Carle Hospital, 9/14/08	$ 715.85
Christie Clinic, 4/26/10-1/20/10	$30,057.00
Eastern IL Emergency Physicians, 5/10/08	$ 356.00

Illini Open MRI, 5/19/10	$ 1,920.00
Provena Covenant Medical Center, 8/26/10-8/27/10	$26,113.63
Provena Covenant Medical Center, 8/31/10	$ 576.40
Lakeland Radiologists, 8/27/10	$ 29.13
Premiere Anesthesia, 8/26/10	$ 1,275.00
Shemauger, 8/31/10	$ 325.00
Total:	**$91,427.68**

Respondent shall pay $91,427.68 for medical services, as provided in Section 8(a) of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent shall pay any unpaid, related medical expenses according to the Fee Schedule and shall provide documentation with regard to said payment calculations to Petitioner.

ATTACHMENT K

In support of the Arbitrator's findings on the issue of **(K) What amount of compensation is due for Temporary Total Disability?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner was removed from work by Provena Hospital emergency room physician on May 10, 2008 until released by Occupational Medicine. (P.X.3)

Petitioner testified and the records confirm that Dr. Philbert Chen, and other Occupational and Orthopedic Medicine Physicians at Carle Clinic, kept the Petitioner on light duty restrictions from May 12, 2008 through January 14, 2010 when Dr. Philbert Chen released Petitioner with permanent restrictions with respect to her right shoulder injury. (P.X. 4)

Petitioner testified that she advised Lou Anne Myers of her light duty work restrictions after her initial injury at which time she was advised that Respondent did not have light duty work. This testimony was un-rebutted and as such is taken as true.

On July 10, 2010, the Petitioner met with Elizabeth Skyles of Skyles Vocational Consulting. Skyles was hired by the Respondent to implement vocational services and assist the Petitioner in locating employment with the permanent work restrictions outlined by the Functional Capacity Evaluation performed on January 11, 2010. (P.X.14) Ms. Skyles prepared a resume for Petitioner and Petitioner began a job search. (P.X.14) Ms. Skyles provided the Petitioner with job leads. (P.X.14) On July 15, 2010, Petitioner met with and informed Ms. Skyles that of the six job leads provided none had any open positions. (P.X.14) Petitioner also contacted ten prospective employers on her own. (P.X.14)

Petitioner advised Ms. Skyles on August 12, 2010 that she was scheduled to have left shoulder surgery. (P.X.14) Vocational assistance ended after the Petitioner underwent left shoulder surgery with Dr. Love.

Petitioner continued to receive medical care for her left shoulder and was removed from work after August 26, 2010 while receiving care from Dr. Baisa and Dr. Love at the Christie Clinic. (P.X. 11, P.X.19, p. 10) On July 12, 2011, Petitioner was released with a five pound lifting restriction on the left arm. (P.X.27)

Respondent offered no evidence that it ever offered the Petitioner a temporary position within her restrictions until December 19, 2012.

Petitioner performed a job search after Dr. Love released the Petitioner from her care with permanent restrictions.

Having found the left shoulder condition to be causally related to the accident, the Arbitrator finds that the Petitioner was temporarily and totally disabled from March 11, 2008 through July 12, 2011, the date that Dr. Love placed permanent work restrictions on Petitioner's left arm. The Arbitrator further notes that Petitioner was engaged in a good faith and diligent job search from shortly after July 12, 2011 through December 19, 2012 and finds that Petitioner was entitled to maintenance benefits from July 13, 2011 through November 21, 2012, the date upon which Jim Ragains opined that a stable labor market did not exist within which Petitioner might find suitable employment. (P.X.22)

ATTACHMENT L

In support of the Arbitrator's findings on the issue of **(L). What is the nature and extent of the injury?,** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The Petitioner sustained serious injuries which were causally related to her accident of May 10, 2008. She sustained a full thickness tear of her rotator cuff on her dominant right side. While the tear was described as small by Dr. Gurtler, he was not able to completely repair the tendon. After performing two surgeries, an MRI performed in late 2009, some eight months after the second surgery and after a long course of physical therapy was completed, revealed a "tiny joint sided supraspinatus defect". (PX 4) Dr. Gurtler decided that no additional surgery was indicated and referred the Petitioner to occupational physicians to consider restrictions. Those restrictions, established by a functional capacity evaluation and subsequent examination by Dr. Chen, left the Petitioner with permanent restrictions,which in and of themselves and prevent her from returning to her prior occupation.

The Petitioner's left shoulder injury consisted of a partial thickness rotator cuff tear, along with an impingement. Dr. Love treated the condition surgically on August 26, 2010, and again therapy was performed. The Petitioner developed a frozen shoulder, had subsequent therapy with aggravations of the condition and was released with a permanent restriction of no lifting over 5 pounds with the left arm and instruction to do primarily right-handed work. (PX 27)

The Respondent at that time did not offer the Petitioner any type of work. Instead they elected to resume providing vocational help which they had briefly provided prior to the Petitioner's left shoulder surgery. Between July 12, 2011 and November 2012, the Petitioner met with and followed the advice of two vocational rehabilitation providers. The evidence showed that she followed up on countless job leads provided by both the rehabilitation specialists and ones that she found herself. No jobs were produced as a result of that job search. The parties agree that the job search was done in good faith. Mr. Morgan, the second vocational specialist hired by the Respondent, noted on October 1, 2012 that "Ms. Williams continues to supply documentation of her job search efforts and in meeting her goals for employers contacts outlined in the rehabilitation plan." (PX 24)

The Reliance Elevator decision, which the parties cite on the issue of whether a subsequent job offer by the Respondent amounted to a sham, also contains an excellent analysis of the requirements in proving odd-lot

permanent and total disability. First, the Petitioner's medical condition should be not so severe as to make her obviously unemployable. Such is the case with the Petitioner. She then has the burden of showing that she is so handicapped that she cannot be regularly employed in any well-known branch of the labor market. The Appellate Court said that this element could be shown by the diligent, but unsuccessful job search. Reliance Elevator Company v. The Industrial Commission, 309 Ill. App. 3d 987 (1999). The Petitioner sustained this burden of proof through the vocational rehabilitation reports and her own job logs. (PX 14,20,24)

The burden, the Court explained, then shifts to the employer show that suitable work is regularly and continuously available to the claimant. Id. at 991. In order to meet that burden, the Respondent, on December 19, 2012, offered the Petitioner a job. The issue is simply whether that job offer satisfied the Respondent burden in this case. If so, the claim should be compensated under either Section 8 (d) (1) or 8 (d) (2). If not, the Petitioner would qualify for permanent and total disability under Section 8 (f) of the Act.

The Petitioner was offered a position in the Respondent's laundry department, where she had never worked. The job was entitled "Linen Service Worker." (RX6) The job description showed a requirement of physical abilities exceeding those set forth in the Petitioner's permanent job restrictions. It called for lifting laundry bags up to 35 pounds in weight, pushing or pulling laundry carts weighing up to 140 pounds, and loading and unloading up to 150 pounds of laundry in one hour's time. Accordingly, job would have to be modified in order for the Petitioner to perform it. Tracy Harris, the Respondent's HR Director, testified about the job modifications. She said the job required one to load and unload clothing into and out of a washer and dryer. The clothing would then have to be sorted and folded. Harris said that the Petitioner could perform the job without having to lift over 5 pounds with her left arm. She did not explain how the job could be performed while also limiting right arm lifting no more than 10 pounds to the waist and 7 1/2 pounds to the head, all on an occasional basis. She said that the Petitioner could use carts to move the laundry around and that she can basically work at her own pace, lifting whatever amounts and weights of clothing that she felt she could handle. She did, however, acknowledge that the job required Petitioner to use her arms throughout the entire work day.

James Ragains, a well credentialed vocational expert familiar with jobs in the central Illinois region, also testified about the job offer. He was familiar with the job of linen service worker said that he did not believe that the job could be modified so that the Petitioner could perform it on a regular basis. He wrote that the job, if modified,would not be one that existed in the open job market. (PX 26)

In looking at the restrictions imposed upon the Petitioner, the job description for linen service work and the substantial accommodations suggested by Ms. Harris, the Arbitrator does not believe that the job offered satisfied the Respondent's burden of proof set forth in the Reliance case. The Arbitrator does not feel that the Petitioner could be reasonably expected to perform the job for any length of time. The Petitioner would likely not be able to fold, sort and handle wet and dry clothes and linens throughout the course of a normal workday. The restriction from Dr. Chen requires that she lift only occasionally. In addition, the job described by Ms. Harris represents a huge deviation from the Linen Service Worker job, which is a regular job for the Respondent. There is very little chance that the modified job would represent "regular and continuously available" work. Reliance at 991. The law simply does not allow an employer to come in at the eleventh hour, and offer a worker a made up position in order to meet the standard set forth by the Court.

Respondent further argued that the surveillance video taken of the Petitioner December 2012 showed that she would be able to perform the job. The video however does not show the Petitioner doing anything with her arms and really is not probative on any issue before the Arbitrator. The Arbitrator also notes Respondent did not call any of its vocational experts to testify as to the appropriateness of the job offered and that neither expert identified the Linen Service Worker as being open and within the Petitioner's residual functional ability.

The Arbitrator finds Ragains' testimony more credible in that the position offered could not reasonably be accommodated to fit the Petitioner's permanent restrictions, and such a position does not exist on the open labor market and, therefore, is not continuously available.

The Arbitrator finds the Petitioner has carried her burden of proving that she falls into the odd-lot category of permanent and total disability, which shifted the burden to establish evidence that suitable employment was continuously available in some well known branch of the labor market and the Respondent failed to satisfy this burden of proof.

The Petitioner is entitled to receive the minimum permanent and total disability benefit in effect at the time of her accident, $441.93, commencing November 22, 2012, the day after Ragains' vocational rehabilitation evaluation and report was issued.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NANCY WATKINS,

Petitioner,

vs.

NO: 12 WC 17286

14IWCC0035

MASTERBRAND CABINETS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Petitioner 7.5% loss of use of each hand. We modify the Arbitrator's decision to award Petitioner 12% loss of use of each hand.

After considering the five factors as required by the Act, the Commission increases the Petitioner's permanent partial disability award to 12% loss of use of the right hand and 12% loss of use of the left hand. The five factors we considered are: (1) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment"; (2) the occupation of the injured employee; (3) the age of the employee at the time of the injury; (4) the employee's future earning capacity; and (5) evidence of disability corroborated by the treating medical records.

The first factor is the AMA impairment rating. Respondent sent Petitioner to be evaluated by Dr. Benson for an impairment rating. Overall, Dr. Benson found Petitioner's impairment to be only 1% of the arm and person as a whole, after rounding up. Dr. Benson considered that Petitioner had to slightly modify her usual work technique because of the injury to her hands. He also noted Petitioner only has minor or mild issues with daily living activities, such as opening a tight jar or cutting food with a knife. Based on Petitioner's minor ongoing issues and the impairment rating, Dr. Benson found Petitioner's impairment to be 1% of the arm and the person as a whole.

The second factor is the employee's occupation. Petitioner works as an auditor for a cabinet manufacturer. She is required to use her hands to lift cabinets and make any necessary repairs to the cabinets, which involves using tools. Petitioner has returned to work full time and full duty for Respondent and appears to no longer be working a second job at a convenience store, per her testimony. Petitioner's occupation requires her to use her hands for fine manipulation on a regular basis throughout the work day. Petitioner also testified she notices some soreness in her palms after work.

The third factor is the employee's age at the time of the injury. Petitioner was 46 years old and no evidence was presented about how her age might affect her disability.

The fourth factor is the employee's future earning capacity. Petitioner returned to her employment full time and full duty at Respondent. She makes the same rate of pay or more as she did before the injury. She did not present evidence as to how her injury may affect her future earning capacity and it does not appear it will have an impact.

The final factor is the evidence of disability corroborated by treating medical records. Petitioner's records are clear that she developed bilateral carpal tunnel syndrome through repetitive use of her hands at work. Petitioner sought appropriate treatment for her symptoms, including an EMG which showed evidence of carpal tunnel syndrome. She eventually underwent bilateral carpal tunnel release, followed by a course of therapy. Petitioner's treatment appears appropriate and the medical records support her complaints.

We further note that Petitioner voices minor continuing complaints from her repetitive trauma injury. She testified that she has good and bad days depending on how often she has to use her hands and on a bad day she will experience tenderness and tingling in her hands. Petitioner does not continue to treat for her carpal tunnel syndrome and does not take any medications for it.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $451.45 per week for a period of 9-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

14IWCC0035

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $406.31 per week for a period of 49.2 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 12% loss of use of the right hand and 12% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
TJT: kg
O: 1/14/14
51

Thomas J. Tyrrell

Daniel R. Donohoo

DISSENT

I respectfully dissent from the decision of the majority. I would affirm and adopt the Arbitrator's decision, and would specifically note that the majority upon making the same findings as the Arbitrator modified and increased Petitioner's award. Arbitrator Lindsay's award was both thorough and in compliance with the Act as recently reformed. The majority does not appear to modify or take issue with any findings set forth by the Arbitrator and as such does not present itself with a basis to disturb the award of the Arbitrator. I would affirm and adopt this decision in its entirety.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WATKINS, NANCY
Employee/Petitioner

Case# **12WC017286**

MASTERBRAND CABINETS
Employer/Respondent

14IWCC0035

On 7/11/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1979 LAW OFFICE OF MICHAEL M WOJITA
308 W STATE ST
SUITE 402
ROCKFORD, IL 61101

5153 DUGAN & VOLAND
CAROL M WYATT/MOLLY E CZERNIK
3388 FOUNDERS RD SUITE A
INDIANAPOLIS, IN 46268

14IWCC0035

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nancy Watkins
Employee/Petitioner

v.

Masterbrand Cabinets
Employer/Respondent

Case # 12 WC 17286

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **May 15, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0035

FINDINGS

On **11/18/2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$35,213.79**; the average weekly wage was **$677.18**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3,074.19** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in non-occupational disability benefits, and **$0** for other benefits for which credit may be allowed under Section 8(j) of the Act.

Respondent is entitled to a credit of **$0** in medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $451.45/WEEK FOR 9 5/7 WEEKS, COMMENCING 6/21/2012 THROUGH 8/27/2012, AS PROVIDED IN SECTION 8(B) OF THE ACT.

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $406.31/WEEK FOR 28.5 WEEKS, BECAUSE THE INJURIES SUSTAINED CAUSED THE 7.5% LOSS OF THE EACH HAND, AS PROVIDED IN SECTION 8(E) OF THE ACT.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 8, 2013
Date

JUL 11 2013

Nancy Watkins v. Masterbrand Cabinets, 12WC17286

The issues in dispute are temporary total disability benefits and the nature and extent of Petitioner's injuries. Witnesses testifying before the Arbitrator included Petitioner, Cheryl Ryan, and Grant Roehrs.

In support of the Arbitrator's Decision, the Arbitrator finds as follows:

Respondent is a manufacturer of kitchen and bathroom cabinetry. Petitioner testified she has worked for Respondent since March of 2004 as an auditor. As an auditor Petitioner would use a hand drill/screw gun, hammer, pliers and other hand tools to perform a portion of her duties. In November of 2011 Petitioner began to notice pain and numbness in both hands as well as a loss of grip strength. She notified her employer of her symptoms and was enrolled in Respondent's Wellness Center to treat her symptoms. The parties stipulated that Petitioner sustained a repetitive trauma injury to her hands on November 18, 2011. (AX 1)

Because Petitioner's symptoms were not responding to treatment at the Wellness Center Petitioner was referred to Dr. Hartman on February 20, 2012. An EMG performed on February 23, 2012 revealed moderately severe bilateral carpal tunnel syndrome, more so on the right than the left. (PX 1)

Dr. Hartman referred Petitioner to Dr. Naam for a surgical consultation. Dr. Naam examined Petitioner on May 1, 2012 and recommended Petitioner undergo a surgical release of her carpal tunnels in both of her wrists. (PX 2) Dr. Naam noted Petitioner had more complaints with regard to her left hand than her right (dominant) hand.

Petitioner continued working for Respondent until June 18, 2012, shortly before her first surgery. (PX 2)

On June 21, 2012 Dr. Naam performed a left carpal tunnel release at the Effingham Ambulatory Surgery Center. (PX 4) The operative report notes Petitioner's left median nerve was moderately congested. (PX 4) Following surgery Petitioner experienced bleeding from the wound and she returned to surgery where bleeding from muscle tissue was noted and controlled. Petitioner's numbness and tingling in her left upper extremity subsided after surgery. (PX 2,4)

According to Dr. Naam's notes, Petitioner remained off work as of June 28, 2012. (PX 2)

Petitioner's sutures were removed on July 3, 2012 and no signs of infection were noted. Petitioner was then referred for scar massage and active range of motion therapy. Dr. Naam's office notes indicate Petitioner reported that no light duty was available at work so he instructed her to remain off work for two more weeks. (PX 2)

On July 16, 2012, Dr. Naam noted Petitioner was doing very well and she was very happy with the operative results. Dr. Naam released Petitioner to return to one-handed duty for one week, if it was available. (PX 2)

Cheryl Ryan, Respondent's safety associate, testified that light duty is typically available. Ms. Ryan further testified that Respondent has a light duty policy whereby employees with work-related restrictions are accommodated in a light duty position for up to ninety days. Ms. Ryan testified that Petitioner came in on July

16, 2012 with a paper and reported she was going to be going to be off work in a few days as she was going to be undergoing another surgery. Petitioner was told not to return to work between July 16, 2012 and July 23, 2012 because Petitioner would be going back off work on July 23rd due to her second surgery.

A right carpal tunnel release was performed on July 23, 2012. (PX 6) The operative report indicated a moderately congested median nerve. (PX 6) Petitioner was kept off work for one week. (PX 2)

Following the carpal tunnel release surgery Petitioner underwent removal of her sutures followed by physical therapy at Working Hands through October 2, 2012. (PX 2, 7)

On August 7, 2012 Petitioner returned to see Dr. Naam and his notes indicate light duty work was unavailable with Respondent. He kept her off work for two weeks. (PX 2)

Petitioner received temporary total disability benefits between June 24, 2012 and August 6, 2012. (AX 1) Petitioner did not receive any further temporary total disability benefits after August 6, 2012.

Dr. Naam re-examined Petitioner on August 28, 2012. Both scars had completely healed; a slight degree of tenderness to them was noted. Active range of motion was examined. Petitioner had 60 degrees extension and 60 degrees flexion on the right with 63 degrees extension and 55 degrees flexion on the left. Petitioner's grip strength was 24 lbs. on the right; 36 lbs. on the left. Her lateral pinch was 6 lbs. on the right and 11 lbs. on the left. Palmar pinch was 6 lbs. on the right and 11 lbs. on the left. Petitioner was told to continue scar massage and active range of motion exercises. Petitioner was released with light duty restrictions (no lifting over five pounds) if available. (PX 2)

Respondent did accommodate Petitioner's restrictions and she returned to work in a light duty capacity on August 29, 2012.

Petitioner's medical records indicate that as of September 18, 2012 Petitioner's scars were completely healed with minimal tenderness over the scars. Petitioner was doing very well and grip strength and active range of motion were continuing to improve. Petitioner was released to unrestricted duty as of September 19, 2012. (PX 2)

Petitioner was last seen at Working Hands on October 2, 2012. At that time she reported increased bilateral tenderness although she noted decreasing tenderness with use of a "gel shell." Petitioner also reported "crampiness" and aches on the ulnar aspect of her palm as well as the ring and small finger after use. Measurements for active range of motion and strength were taken. Both measurements reflected functional limits with strength measurements for the right upper extremity being described as "slightly decreased." (PX 7)

Dr. Naam released Petitioner from his care on October 2, 2012 to return as needed. At that time, Petitioner denied any further tenderness over her scars and she reported she was doing "very well." His office notes contain no mention or discussion of future medical care, including the need for any ongoing pain medications. Active range of motion and grip strength had continued to improve. (PX 2) Petitioner has not returned to Dr. Naam regarding her hands since then.

Petitioner has returned to her regular job for Respondent. She earns the same or more than she did pre-injury. Petitioner has not required any accommodation of her job duties for Respondent nor has she complained of any problems or pain in performing her job duties for Respondent since receiving her full duty release from care.

Petitioner's supervisor, Grant Roehers, testified that he has not observed Petitioner having any difficulty with the performance of her job duties. Petitioner testified that she has not lost any seniority as a result of her injury.

Petitioner testified that she has good and bad days and that she experiences some numbness and tingling when reaching into tight spots and/or awkward positions.

Petitioner acknowledged that she did not check with Ms. Ryan or anyone else at Respondent regarding whether her restrictions could be accommodated at that time. Since the doctor did not believe any light duty work was available he kept Petitioner off work.

Petitioner acknowledged that she has also held a part-time position as a cashier at a local convenience/gasoline store while working for Respondent. Petitioner works/worked[1] there approximately five hours per week.

Petitioner was evaluated by Dr. Benson on November 28, 2012 for the assignment of an AMA permanent partial impairment rating pursuant to the 6th Edition of the AMA Guides to Impairment. (RX C) On examination, Dr. Benson found no evidence of weakness in her hands or thenar atrophy. Petitioner's neurovascular function was intact. Petitioner had well-healed scars of approximately 1.5" in length on the palms of her hands. She complained of some occasional soreness in that area. Petitioner displayed normal digit motion and normal wrist motion bilaterally. Based on the Petitioner's responses to the QuickDash report and her examination, Dr. Benson issued a 1% upper extremity rating which he converted to a 1% whole person impairment based on the Guides. (RX C)

In the QuickDash Report, Petitioner indicated that at the time of evaluation, and within the previous week, her hand problem had not interfered at all with her social activities, sleeping, or work or regular daily activities. (RX B) B) She noted moderate difficulty opening a jar, and mild difficultly in a few activities such as recreational activities requiring impact or force in the hands, pain, and using a knife to cut food. (RX B)

Ms. Ryan testified that light duty work was available as of August 7, 2012 and Petitioner's restrictions could have been accommodated.

Ms. Ryan further testified that on July 16, 2012, Petitioner was told Respondent would accommodate her restrictions when she received them again.

Cheryl Ryan further testified that Petitioner has the ability to bid into a higher pay grade for other positions, such as an Assistant Team Leader position, a position which would not require additional education. Petitioner's income potential has not been impacted by her injury according to Ms. Ryan.

Petitioner was born on December 5, 1964. (AX 2)

The Arbitrator concludes:

1.Temporary Total Disability (TTD).

Petitioner is entitled to TTD benefits from June 21, 2012 through August 28, 2012. Petitioner underwent bilateral carpal tunnel releases on June 21, 2012 and July 23, 2012. Dr. Naam restricted Petitioner from returning to work completely following the June 21, 2012 surgery through July 16, 2012,

[1] Petitioner testified she "gave notice." The Arbitrator is unclear if Petitioner still works there or not.

and allowed Petitioner to return to work on a light duty basis through July 23, 2012. (PX 3) Petitioner testified she presented Respondent with the light duty restrictions on July 16, 2012, but Respondent did not accommodate the restrictions at that time. Safety director, Cheryl Ryan's testimony confirms that Petitioner presented Dr. Naam's July 16, 2012 restriction note to Respondent and Respondent did not offer a position within the restrictions at that time.

Following her surgery on July 23, 2012 Dr. Naam again restricted Petitioner from returning to work through August 7, 2012. On August 7, 2012 Petitioner informed Dr. Naam her employer did not have light duty work available at that time. As before, Dr. Naam continued to restrict Petitioner from work. On August 28, 2012 Dr. Naam allowed Petitioner to return to work with light duty restrictions until September 18, 2012 after which time she was released to return to work without restrictions. (PX 3)

Dr. Naam kept Petitioner off work after her second surgery just as he had after the first surgery. Petitioner was under the impression no light duty was available on July 3rd and reported as much to the doctor. He kept her off work. Respondent paid TTD benefits while Petitioner remained off work during that time and said nothing to Petitioner or her attorney to suggest Petitioner had misunderstood the availability of light duty at that time (July 3, 2012). Dr. Naam imposed restrictions on July 16, 2012 and while the Arbitrator believes Respondent could have accommodated her at that time Respondent chose to have Petitioner remain off work due to her upcoming surgery. Respondent kept Petitioner off work due to her upcoming second surgery. While Ms. Ryan testified Respondent "typically" accommodates restrictions, Petitioner had no restrictions imposed on her after the second surgery until August 28, 2012. Respondent's conduct with Petitioner after her first surgery left Petitioner under the reasonable impression she was correct when she told the doctor on July 3, 2012 that no light duty was available. Accordingly, Petitioner was not acting unreasonable when she informed Dr. Naam on August 7, 2012 that her employer did not have light duty work available as, for whatever reason, she was under the impression in early July of 2012 that light duty work was unavailable.

2. Nature and Extent.

Pursuant to Section 8.1b of the Workers' Compensation Act, the following criteria and factors must be considered in assessing permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to these factors, the Arbitrator notes:

1. The reported level of impairment under the AMA Guides.

With regard to the AMA impairment rating, the Arbitrator takes into account Dr. Benson's impairment rating of 1 % total body impairment. When evaluated by Dr. Benson, Petitioner was one and one-half months post MMI. She reported no difficulty in the majority of all activities and no difficulty in sleeping, working or social activities of daily living. Moderate difficulty opening a jar was noted as well as mild difficulty with using a knife to cut food and certain recreational activities. Dr. Benson was also aware of Petitioner's occasional soreness in the palm of her hand. Petitioner reported mild difficulty using her "usual technique" at work and performing her usual work activities.

2. The occupation of the injured employee.

Petitioner's current occupation is that of an auditor in a manufacturing environment. Petitioner returned to that position and has continued performing it full-time and full duty. Petitioner also works/worked as a part-time cashier for a convenience store. No evidence was presented indicating any problems performing cashier duties or that Petitioner may have quit that job due to her injuries. She uses her upper extremities in both occupations. Petitioner repairs and inspects cabinets before they are shipped. She uses hand tools. As a cashier she stocked, swiped, and mopped. Petitioner has returned to her usual and customary occupation, albeit she notices some occasional soreness when working.

3. The age of the employee at the time of the injury.

At the time of her accident, Petitioner was 46 years old. No evidence was presented as to how Petitioner's age might affect her disability.

4. The employee's future earning capacity.

No evidence regarding Petitioner's earning capacity was presented by Petitioner. Respondent produced evidence indicating Petitioner's injury has not adversely impacted her current wage rate with Respondent nor does it appear that it will impact her future earning capacity. No evidence suggests a diminishment in Petitioner's future earning capacity as a result of her injury.

5. Evidence of disability corroborated by the treating medical records.

Petitioner developed bilateral carpal tunnel syndrome due to her work activities with Respondent. She underwent surgical carpal tunnel releases to repair her injuries. Petitioner testified she continues to experience tenderness to both hands with some activities. Petitioner was prescribed "gel shells" bilaterally to wear as needed during functional activities, including work. (PX 7) While the shells have helped decrease tenderness during hand usage, she reported "crampiness" and aching in the ulnar aspect of her palm as well as her ring and small fingers after use. The Arbitrator recalls no testimony being elicited at arbitration to indicate if she continues to use the shells and, therefore, draws no inferences therefrom. Petitioner takes no medications. She has no permanent restrictions.

Petitioner's medical records note active range of motion and strength within functional limits and complete healing over the incision sites. Petitioner's complaints are corroborated by Dr. Naam's records and the therapy records. Petitioner's testimony was credible and forthright.

Overall, the evidence supports an award of permanent partial disability. Petitioner had surgery and her strength and range of motion, while in the functional range, have been diminished. After considering all of the above factors, the Arbitrator concludes that Petitioner has sustained permanent partial disability of 7.5% of each hand ((190 weeks x 7.5% x 2) x $406.31).

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
MADISON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACKIE DUBREE,

Petitioner,

vs.

NO: 09 WC 33652

14IWCC0036

VILLAGE OF LIVINGSTON,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection and medical expenses, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

We modify the Arbitrator's order with respect to mileage reimbursement and temporary total disability benefits. The Arbitrator awarded Petitioner mileage reimbursement but failed to include that in his order. The Commission modifies the Arbitrator and only awards Petitioner mileage for her out of state treatment, specifically her visits to Dr. Boutwell, Dr. Gornet and Dr. Gross.

Further, we clarify the Arbitrator's temporary total disability award. The Arbitrator awarded Petitioner temporary total disability benefits for 45 weeks, from February 6, 2002 through December 13, 2013. We clarify that Petitioner is awarded temporary total disability benefits from February 6, 2012, through December 13, 2012, for a total of 44-4/7 weeks.

14IWCC0036

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $261.83 per week for a period of 44-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for further medical treatment to the Petitioner, including but not limited to orthopaedic and neurosurgical evaluation, physical therapy, therapeutic injections, and/or cervical surgery, and/or fusion, if necessary, and temporary total disability benefits associated with such treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $33,993.91 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall reimburse Petitioner for out of state mileage through October 2012.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
TJT: kg
O: 11/26/13
51

Thomas J. Tyrrell

Daniel R. Donohoo

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

DUBREE, JACKIE
Employee/Petitioner

Case# **09WC033652**

VILLAGE OF LIVINGSTON
Employer/Respondent

14IWCC0036

On 2/20/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4730 BOLLWERK & RYAN LLC
FRANK J CARRETERO
10525 BIG BEND BLVD
ST LOUIS, MO 63122

0299 KEEFE & DEPAULI PC
TOM KUERGELEIS
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

14IWCC0036

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JACKIE DUBREE
Employee/Petitioner

v.

VILLAGE OF LIVINGSTON
Employer/Respondent

Case # **09** WC **033652**

COLLINSVILLE (Lee)

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **12/13/2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Section 8 (a) prospective medical care**

14IWCC0036

FINDINGS

- On the date of accident, **10/16/08**, Respondent ***was*** operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
- On this date, Petitioner ***did*** sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident ***was*** given to Respondent.
- In the year preceding the injury, Petitioner earned **$20,423.52**; the average weekly wage was **$392.76**.
- On the date of accident, Petitioner was **39** years of age, ***single*** with **2** dependent children.
- Necessary medical services have not been provided by the respondent.
- To date, $33,816.06 has been paid by the respondent for TTD and/or maintenance benefits.
- THE RESPONDENT IS ENTITLED TO CREDIT OF $6,716.75 UNDER 8(J) OF THE ACT.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $261.83/week for 45 weeks, from 2/6/2002 through 12/13/2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.
- The respondent shall pay $33,993.91 for medical services, as provided in Section 8(a) of the Act.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

****Respondent shall authorize and pay for further medical treatment to the Petitioner, including but not limited to orthopaedic and neurosurgical evaluation, physical therapy, therapeutic injections, and/or cervical surgery and/or fusion, if necessary, pursuant to Section 8(a). The Respondent shall also pay such temporary total disability benefits as may be associated with such treatment.**

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 0.13% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Edwd Lee
Signature of Arbitrator

2/16/13
Date

ICArbDec19(b)

FEB 20 2013

Jackie Dubree v. Village of Livingston (IWCC Case #: 09 WC 33652)

The Arbitrator finds the following facts regarding all disputed issues:

Petitioner/Employee Jackie Dubree (hereinafter, "Jackie" or "Employee") on or about October 16, 2008, was employed by the Village of Livingston, Illinois, (hereinafter, "Employer" or "Respondent") as a laborer. The employee and employer were operating under the Illinois Workers' Compensation or Occupational Disease Act. As a laborer, he along with his fellow employees in the department, were essentially responsible for water, sewer, streets and vehicle maintenance for the Village of Livingston.

On October 16, 2008, employee was using a sledgehammer and disposing of pieces of concrete in a bin when while unloading a bin of concrete he felt a "pop" in his back and severe pain between his shoulder blades (Pet. Ex. 1). On the day of the accident, Jackie was taken to Community Memorial Hospital where he complained of and was diagnosed with "upper back pain" (Exhibit 3-1). Jackie was examined and treated. He was given prescription medication for the pain and referred to Dr. Manish Mathur at the Staunton Clinic, (Pet. Ex. 7-1).

At the Staunton Clinic, Dr. Mathur diagnosed Jackie with a "probable acute lower cervical disc prolapsed with significant pain and radiculopathy" and recommended that Jackie undergo an MRI of the cervical spine. The cervical MRI taken on October 21, 2008 revealed a posterior disc bulge at C6-7 (Pet. Ex. 7-1). On October 28, 2008, Dr. Mathur stated that Jackie was miserable, with severe pain in neck and muscle spasms and requested a neurosurgical opinion and took him off work (Pet. Ex. 7-1).

Jackie was referred to Dr. Andrew Youkilis, a neurosurgeon. On December 18, 2008, Dr.Youkilis evaluated Jackie and stated that "presently, Jackie has neck and intrascapular pain without significant radicular symptoms or findings." Dr. Youkilis recommended, smoking cessation, cervical traction and an epidural steroid injection and a follow-up in two months and stated that, "should his symptoms be persistent at that time, we will discuss a C6-7 anterior cervical discectomy and fusion at his next visit." (Pet. Ex. 9-1).

On January 15, 2009, Jackie saw Dr. Anne Christopher, a pain management specialist at the Brain and Spine Center. Dr. Christopher performed an epidural steroid injection at the C6-7 level (Pet. Ex. 9-1). Jackie reported no relief from the procedure and Dr. Christopher documented minimal reduction in pain (Pet. Ex. 9-1). On January 17, 2009, Jackie returned to Dr. Mathur complaining of severe neck pain. Dr. Mathur prescribed Toradol, Vicodin and Flexeril. (Pet. Ex. 7-1).

On March 30, 2009, at the request of the Respondent/Insurance carrier, Jackie was referred to Dr. Steven C. Delheimer for an independent medical evaluation examination (Pet. Ex. 4-1). Jackie complained of pain in the neck and between the shoulder blades and pain that shoots down his arms. The pain was 7 out of 10. He also had headaches. Dr. Delheimer's opined that Jackie "suffered, at most, a soft tissue injury as a result of the incident of October 16, 2008 ... I consider him capable of returning to work without restrictions and in need of no further treatment or diagnostic studies" (Pet. Ex. 4-1).

His primary care physician, Dr. Mathur, continued to treat Jackie due to his complaints of neck and upper back pain. On April 15, 2009, Dr. Mathur stated that Jackie is to stay off work and recommended a repeat MRI (Pet. Ex. 7-1). The MRI taken on April 21, 2009, at Anderson Hospital showed a disc bulge at C6-7 and "mild to moderate bilateral neural foraminal stenosis" according to Dr. Mathur (Pet. Ex. 7-1). Due to Jackie's persistent neck and upper back pain, on August 07, 2009, Jackie was referred to Dr. Kristina Naseer.

On October 23, 2009, Jackie saw Dr. Naseer. Dr. Naseer eventually performed three injections, the first was apparently a midline epidural steroid injection followed by a C7-T1 extra-foraminal injection. The first one helped, the last 2 did not. Jackie was still having shooting, aching, sharp, burning pain that was constant. Jackie was also using a tens unit that was giving him some temporary relief. Dr. Naseer opined that Jackie still had stiffness and some limitation with ROM of cervical spine and that it was "likely his pain will be chronic and he will have to deal with some degree of pain for the rest of his life." (Pet. Ex. 5-1).

The employer refused to provide Jackie with further medical treatment and benefits. On December 30, 2009, Employee filed his first request for a 19b hearing. Before the 19b hearing was to be heard, Employer authorized an evaluation with a neurosurgeon, Dr. James J. Coyle. Dr. Coyle saw Jackie on January 19, 2010 for an evaluation. Dr. Coyle reviewed Jackie's medical history and concluded that "It is my impression within a reasonable degree of medical certainty that Dr. Mathur was correct when he initially diagnosed Mr. Dubree several days after his work injury. At that time he felt that [the] neck pain was due to a lower cervical problem. Mr. Dubree is now over year out from his injury and is still very symptomatic. I do not think that this is a soft tissue problem; it is consistent with discogenic pain and cervical radiculopathy" (Pet. Ex. 9-1). Dr. Coyle wanted an up-to-date advanced cervical MRI with sedation and stated that at this time Jackie could not work and has not reached MMI (Pet. Ex. 9-1).

On May 4, 2010, Jackie had an advanced cervical MRI with sedation. On May 12, 2010, Jackie returned to Dr. Coyle who interpreted the MRI as showing a "disc prolapse at C6-7 which is causing foraminal impingement which the radiologist referred to as, 'Bilateral moderate to moderately severe foramina stenosis.' There is a small disc protrusion at C5-

C6" (Pet. Ex. 9-2). Dr. Coyle opined that Jackie's work injury of October 16, 2008, was a substantial cause of his current radiculopathy and symptoms and need for treatment. He further stated, "At this point, appropriate treatment for him would be an anterior cervical discectomy and arthrodesis. I recommend confining surgery to the C6-C7 level because the finding at C5-C6 is relatively subtle" (Pet. Ex. 9-2).

On August 23, 2010, Jackie underwent surgery which included an "anterior cervical microscopic discectomy, bilateral foraminotomy at C6-C7, anterior interbody arthrodesis at C6-C7...and anterior cervical plate" (Pet. Ex. 9-3). Jackie's follow-up with Dr. Coyle on September 9, 2010, he had residual posterior neck pain; October 12, 2010; November 22, 2010, he had complaints of left upper extremity pain localized around the shoulder and left trapezius with tingling in the left hand; January 11, 2011, also complaints of continued pain in the right arm and shoulder blade; and on March 8, 2011, he complained of continued left upper extremity pain (Pet. Ex. 9-3).

On April 6, 2011, Jackie continued to complain of left shoulder pain and tenderness over the trapezius muscle. "Pain is precipitated by internal rotation of the shoulder and abduction of the shoulder against resistance. He states that his entire arm is hurting." (Pet. Ex. 9-3). Nevertheless, Dr. Coyle stated that Jackie had reached "maximum medical improvement from the cervical decompression and arthrodesis" and that he "would not place any restrictions on him from the standpoint of his cervical spine, but he will need to have the left shoulder evaluated. I do not have any information regarding causation of his left shoulder symptoms" (Pet. Ex. 9-3). Employee testified that he requested additional treatment for his complaints to his neck and shoulder and was denied further treatment by the employer/insurance carrier.

After April 6, 2011, Jackie returned to work but continued to have significant pain to the thoracic area and left arm pain which he described as 10/10 in pain scale. On April 19, 2011, after only several hours working, he went to Community Memorial Hospital emergency room with complaints "of severe back pain between his shoulders....that he has had since he had surgery on his C7 disk. Patient also complains of pain in his left shoulder" (Pet. Ex. 3-2). Jackie testified that after returning to work he worked sporadically and often had to take off work or leave early from work because of his pain.

Because of the employer's failure to provide medical treatment and Jackie's continued complaints, on August 23, 2011, he sought treatment from the Rademacher Chiropractic Clinic (Pet. Ex. 8-1). Dr. Rademacher provided chiropractic therapy from August 23 – December 2, 2011. Due to Jackie's continuing neck and upper back complaints, Dr. Rademacher referred Jackie to a neurosurgeon, Dr. Matthew F. Gornet (Pet. Ex. 9-1) and (Pet. Ex. 1-1).

Employee initially saw Dr. Gornet on October 3, 2011, at the Orthopedic Center of Saint Louis. Jackie's complaints included neck pain, headaches, pain in both trapezius, particular

left shoulder, down the left arm into the hand with numbness. He also has some pain in the left scapular region of hi mid back" (Pet. Ex. 1-1). Dr. Gornet discussed with Jackie a "potential structural problem in his spine". Dr. Gornet believed that the fusion at C6-C7 was solid, but recommended a high quality CT with better imaging to make a further determination. He also recommended a thoracic MRI to evaluate the scapular pain and a nerve conduction test to determine whether there was any residual nerve damage which could cause persistent symptoms (Pet. Ex. 1-1). Dr. Gornet also opined that, "Based on the history I have available, I do believe his current symptoms are casually connected to his original work injury of 2008 lifting the concrete" (Pet. Ex. 1-1).

On December 5, 2011, Jackie returned to see Dr. Gornet and noted that the CT-scan confirmed a solid fusion at the C6-7 area that Dr. Coyle operated on, but "it does also reveal a larger disc herniation at C5-C6 which has progressed from the original scan of 5/4/2010" (Pet. Ex. 1-1). Dr. Gornet also noted that the C5-C6 lesion was definitely present prior to Dr. Coyle's surgery, but it was not as significant as it is now and that "it appeared to be a progression of his original work injury that was treated by Dr. Coyle" (Pet. Ex. 1-1).

Jackie returned to see Dr. Gornet on February 6, 2012. The MRI taken December 5, 2011, of the cervical spine and thoracic spine showed a disc herniation at C5-C6 which was not present on his original film. Dr. Gornet opined that, "that this was a progression of his original work-related injury and subsequent fusion...a fusion is known to place significant adjacent level forces to the level above and below." Dr. Gornet believes that because Jackie has already tried conservative treatment like injections, that "his next option is really surgical treatment including revision surgery with a disc replacement at C5-C6" (Pet. Ex. 1-1). At this time, Dr. Gornet determined that Jackie was temporarily totally disabled and placed him off work from February 6, 2012 to May 6, 2012 (Pet. Ex.1-1). Jackie returned to see Dr. Gornet for a follow-up on April 16, 2012 and noted that he was still waiting for approval for treatment and that Jackie remained temporarily totally disabled (Pet. Ex. 1-2).

On July 16, 2012, Jackie returned to see Dr. Gornet. Dr. Gornet reviewed Dr. Coyle's IME report and felt that because "often shoulder and scapular pain can emanate from more than one source" and due to Jackie's continued shoulder and scapular pain, that an evaluation of the shoulder was appropriate, "although it does not change my opinion that his disc herniation at C5-C6 is causing a portion of his neck and shoulder symptoms" (Pet. Ex. 1-2). Dr. Gornet phrased the issue simply as, "does a cervical fusion at C6-C7 which has been successful at treating a problem, contribute to adjacent level failure and progression of what was a small central disc protrusion in 2010 to a more frank disc protrusion as seen in 2011. The answer in this situation from my opinion is obviously, yes" (Pet. Ex. 1-2). Dr. Gornet opined that cervical operations have a known adjacent level failure associated with them (Pet. Ex. 1-2). Dr. Gornet referred Jackie to Dr. Lyndon Gross for a shoulder evaluation, and stated that Jackie remained temporarily totally disabled (Pet. Ex. 1-2).

Jackie saw Dr. Lyndon B. Gross, an orthopedic surgeon specializing in shoulders, on July 16, 2012 (Pet. Ex. 2-1). (Pet. Ex. 2-1). Dr. Gross treats complex problems of the shoulder and elbow. He examined Jackie due to the fact that Dr. Coyle thought that the problem might still be related to his shoulder and not his neck (Pet. Ex. 2-1). Dr. Gross took a patient history and then performed physical exam and noted that Jackie had "minimal findings with respect to the shoulder...he appears to continue to have pain in the trapezius and scapular region, but it is not significantly changed by my examination of his shoulder which makes me believe that this is probably not related to an intrinsic problem to the shoulder" (Pet. Ex. 2-1). Dr. Gross recommended an MRI arthrogram to determine whether there is any pathology in his shoulder which would be consistent with causing his complaints of left shoulder pain.

On July 26, 2012, Jackie returned to see Dr. Gross after his MRI Arthrogram. The MRI Arthrogram of showed a rotator cuff tendinopathy and a small tear of the superior labrum and some degeneration of the acromioclavicular joint (Pet. Ex. 2-1). Dr. Gross believes that those finding are preexisting more degenerative in nature. Dr. Gross stated that his examination was not consistent with having "rotator cuff tendinopathy, degenerative joint disease, or even a superior labral tear. His pain is in his neck" (Pet. Ex. 2-1). Furthermore, Dr. Gross opined that Jackie's pain extended into the upper back area and down his arm which would be more consistent with a radicular type problem than a problem to his shoulder (Pet. Ex. 2-1).

Based upon the forgoing and in consideration of all evidence, the Arbitrator finds and rules as follows:

1. Employee sustained a herniated disc at the C5-C6 level as a result of a compensable, work related accident dated October 16, 2008, that occurred while in the course and scope of his employment with the Employer.
2. Based on the Employee's testimony, a review of the medical records and Dr. Coyle's opinion that the work accident of October 16, 2008 was a substantial cause of his current radiculopathy and symptoms and need for treatment.
3. Employee's work injury of October 16, 2008, was a substantial cause of his current radiculopathy and symptoms and need for treatment at C5-6 as evident by Dr. Coyle's May 2010 admission, based on his reading of the MRI, there was a disc protrusion at C5-6 and that the "...appropriate treatment for him would be an anterior cervical discectomy and arthrodesis. I recommend confining surgery to the C6-C7 level because the finding at C5-C6 is relatively subtle" (Pet. Ex. 9-2). Dr. Gornet also opined that, "Based on the history I have available, I do believe his current symptoms are casually connected to his original work injury of 2008 lifting the concrete" (Pet. Ex. 1-1).

4. That based on the employee's testimony, after the C6-7 cervical discectomy and arthrodesis, he was released to return to work by Dr. Coyle but due to his continued neck pain, left shoulder pain which extended down the left arm into the hand with numbness, he had difficulty in performing his work duties or working a consistent 40 hour work week. He requested additional medical care which the Employer denied.
5. That after the Employer denied him benefits and further treatment, Employee sought treatment on his own and saw a Dr. Rademacher, a chiropractor, who eventually referred Jackie to a neurosurgeon, Dr. Matthew F. Gornet.
6. That Employee's continued complaints to the neck and shoulder are not related to the shoulder, but rather to his neck (Pet. Ex. 1-2).
7. Employee proved causation between the need for additional medical treatment including further orthopedic and neurosurgical evaluation, cervical surgery and/or fusion, physical therapy, therapeutic injections and his work related accident dated October 16, 2008, by his own testimony, as well as a review of the medical records of Dr. Coyle, Dr. Gornet and Dr. Gross, as well as the reasonable inferences drawn from the same.
8. Employer shall authorize and pay for further medical treatment to Employee's neck, including but not limited to orthopedic and neurosurgical evaluations, cervical surgery and/or fusion, physical therapy, therapeutic injections, if necessary, pursuant to Section 8(a).
9. Employer shall also pay such temporary total disability benefits as may be associated with such treatment.
10. Employee has not reached maximum medical improvement.
11. Employer shall pay the employee Temporary Total Disability benefits $261.83/week for 45 days, from 2/6/2012 through 12/13/2013, as provided by Section 8(a) of the Act, because the injuries sustained caused the disabling condition of the employee, the disabling condition is temporary and has not yet reached a permanent condition pursuant to Section 19(b) of the Act.
12. Employer shall pay $33,993.91 for medical services, as provided in Section 8(a) of the Act and in accordance with the Illinois Medical Fee Schedule (Pet. Ex. 12-1, 13-1, and 14-1).
13. Employer shall reimburse Employee for Mileage through October 2012 (Pet. Ex. 15-1).

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRETT LITTRELL,

Petitioner,

vs.

NO: 09 WC 19838

14IWCC0037

ALM,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

We modify the Arbitrator's award of medical expenses. In his order, the Arbitrator awarded Petitioner $22,717.79 in medical expenses. However, in the body of his decision, the Arbitrator awarded $14,573.95 in medical expenses and denied $5,070.74. We modify the Arbitrator's order to reflect that Petitioner is only awarded $14,573.95 in medical expenses. The Arbitrator denied the following medical expenses, with which we agree: bills from St. Mary's Hospital and Dr. DePhillips totaling $2,085.00; prescription medications from Kroger pharmacy after November 7, 2010, totaling $2,723.74; and bills from St. James Radiology that reflect service dates after November 7, 2010, totaling $262.00. Petitioner is awarded the remaining medical expenses of $14,573.95.

14IWCC0037

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $460.14 per week for a period of 106-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $161.05 per week for a period of 2-4/7 weeks, that being the period of temporary partial disability for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $414.12 per week for a period of 150 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 30% loss of use of a person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,573.95 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $63,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
TJT: kg
O: 11/25/13
51

Thomas J. Tyrrell

Daniel R. Donohoo

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LITTRELL, BRETT
Employee/Petitioner

Case# **09WC019838**

ALM
Employer/Respondent

14IWCC0037

On 2/5/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0400 LOUIS E OLIVERO & ASSOC
DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

0358 QUINN JOHNSTON HENDERSON ETAL
CHRIS CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

14IWCC0037

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BRETT LITTRELL,
Employee/Petitioner

v.

ALM,
Employer/Respondent

Case # **09** WC **19838**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robret Falcioni**, Arbitrator of the Commission, in the city of **Ottawa, IL**, on **12/27/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0037

FINDINGS

On **04/17/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$35,890.92**; the average weekly wage was **$690.21**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$48,455.77** for TTD, **$161.05** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$48,616.82**.

Respondent is entitled to a credit of **$zero** under Section 8(j) of the Act.

ORDER

Respondent shall pay petitioner temporary total disability benefits of $460.14/week for 106-6/7 weeks, commencing 04/21/09 through 05/08/11, as provided in Section 8(b) of the Act.

Respondent shall pay petitioner temporary partial disability benefits of $161.05 for 2-4/7 weeks, commencing 05/19/11 through 05/27/11, as provided in Section 89b) of the Act.

Respondent shall pay petitioner permanent partial disability benefits of $414.12/week for 150 weeks, as provided in Section 8(d)(2) of the Act, because of the injuries sustained caused a 30% loss of use of a person as a whole.

Respondent shall pay petitioner compensation that has accrued from 04/17/09 through 12/27/12, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay petitioner reasonable and necessary medical services, pursuant to the medical fee schedule, of $22,717.79, as provided in Sections 8(a) and 8.2 of the Act.Respondent to receive credit for all sums previously paid hereunder.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

January 4, 2013
Date

FEB - 5 2013

ILLINOIS WORKERS COMPENSATION COMMISSION
OTTAWA SETTING

BRETT LITTRELL	)	
	)	
	)	No. 09 WC 19838
v.	)	
	)	
	)	Arbitrator Robert Falcioni
ALM	)	
	)	
	)	

RESPONDENT'S PROPOSED DECISION AND ARBITRATOR'S FINDINGS OF FACT

ISSUES IN DISPUTE

F. Is Petitioner's current condition of ill-being causally related to the injury ?

J. Were the medical services provided to petitioner reasonable and necessary? Has Respondent paid all appropriate charges for reasonable and necessary medical services ?

K. What temporary benefits are in dispute ?

L. What is the nature and extent of the injury ?

N. Is Respondent Due any credit ?

ARBITRATOR'S FINDINGS OF FACT

Brett Littrell testified that he first began working for respondent in 2004 as a welder. He claimed that he was in a normal state of good health prior to April 17, 2009. Petitioner testified that his back began to hurt so bad at work that he could barely walk. Petitioner was seen at the St. Mary's Hospital Emergency Room on April 19, 2009. (Px. 1). He went to see Dr. Pal who later referred him to Dr. Sinha. (Px 3).

Petitioner told Dr. Sinha that his pain started at the end of March and became progressively worse. Dr. Sinha ordered a lumbar MRI which revealed multiple degenerative changes. (Px 3). Dr. Sinha restricted the petitioner to light duty work as of May 5, 2009 of no lifting beyond 20 pounds and no repetitive bending. (Rx 3).

Petitioner was referred to Dr. DePhillips. Petitioner was referred by a current patient. Petitioner gave a history of his back pain gradually worsening until he was required to go to the emergency room in April of 2009. Dr. DePhillips reviewed the MRI and diagnosed petitioner as suffering from degenerative disc disease at L4-5 and L5-S1. Petitioner had annular tears at each of these levels. Dr. DePhillips restricted the petitioner from working, he was prescribed physical therapy and ordered to undergo some injections.

Petitioner next followed up with Dr. DePhillips on July 20, 2009 He was referred for two lumbar injections.

Petitioner was examined by Dr. Heim on July 22, 2009 at the request of respondent. (Rx 1, Dep Ex. 2). Dr. Heim had concluded earlier that petitioner had suffered an aggravation of his degenerative disc disease. He recommended against epidural steroid injections and instead recommended physical therapy. (Rx 1, Ex 3). After examining the petitioner on July 22, 2009 his opinions did not change. Petitioner did report radiating symptoms into his posterior thigh. (Rx 1, Ex 2).

He was restricted to 10-15 pounds lifting and a four hour work day. Petitioner returned on August 31, 2009 having undergone one injection with some relief. A second injection was recommended. Petitioner returned to Dr. DePhillips on October 5, 2009

having undergone a second injection at L3-4. This did not provide him relief. Dr. DePhillips recommended lumbar discography. (Px 6).

Petitioner followed up on December 7, 2009 and a lumbar interbody fusion at L4-5 and L5-S1 was recommended by Dr. DePhillips. Petitioner followed up on Febraury 24, 2010. Petitioner had a repeat MRI scan. The scan showed severe degenerative disc disease at the L4-L5 and L5-S1 levels with facet arthropathy and mild foraminal stenosis on the right side. The L5 nerve root was compressed. Petitioner was scheduled for a lumbar fusion for February 26, 2010. (Px 4 and Px 6).

Petitioner followed up on March 8, 2010. He complained of soreness at the incision site. He did not report any radicular symptoms into his lower extremities. He was to follow up in three weeks. He was restricted from all work.

Petitioner followed up on April 19, 2010 complaining of occasional back pain. He complained of tingling and numbness in the back of his thighs. He was prescribed Norco and Flexeril.

He saw Dr. DePhillips again on May 17, 2010. He complained of radiating pain into the back of his thighs. He had back pain that was constant and waxed and waned in severity. (Px 6).

Petitioner followed up on June 7, 2010. He reported that the shooting pain into his lower extremities was gone. The interbody cages were in a good position upon reviewing the x-rays. Petitioner reported mechanical low back pain. (Px 6). He was restricted from working.

On June 28, 2010 petitioner advised that he did not have any radicular symptoms. Physical therapy had improved his pain. He rated it a 7 out of 10 versus a previously reported 8 out of 10.

Petitioner followed up on August 3. 2010 stating he had back pain. Physical therapy was recommended. He was given a 10 pound lifting restriction, alternating sitting and standing and no one position for more than 1 to 2 hours.

Petitioner followed up on August 30th, 2010. He completed physical therapy and now work hardening was being prescribed. (Px 6). He saw Dr. DePhillips again. Three weeks of work hardening was recommended followed by a FCE. (Px 6).

Petitioner underwent a FCE on October 12, 2010. (Px 5). Petitioner failed 7 out of 15 performance criteria. It was determined he could work an 8 hour day, five days a week lifting between 26.5 and 35 pounds occasionally, 23.5 to 31.5 frequently and constant of 12-15 pounds. Carrying was limited to 30 pounds occasionally, 15 pounds frequently and 8 pounds constantly. He could push occasionally at 65 pounds while being frequent at 32.5. He could pull occasionally at 78 pounds and frequent at 39 pounds. He was restricted to occasional bending, reaching, climbing, kneeling and crawling. (Px 5).

Petitioner returned to see Dr. DePhillips on October 18, 2010. Dr. DePhillips was unwilling to release the petitioner at MMI pending review of the CT scan. No radicular symptoms were reported. Petitioner was seen again on November 1, 2010 he claimed to have reviewed the CT scan and observed that the interbody fusions had not consolidated. Work conditioning was recommended. No radicular symptoms were reported.

On November 8, 2010, petitioner visited with Dr. DePhillips explaining that he was recently moving chairs in his kitchen and felt a pop in his back. He experienced pain into his left buttock and front of his thigh. (Px 6).

Petitioner saw Dr. DePhillips again on November 15, 2010. Petitioner reported that he opened his door to let his dogs out on November 14, 2010. The wind caught the door and he fell down two steps. X-rays were reviewed and the fusions were consolidating well. Dr. DePhillips restricted the petitioner from working.

Petitioner testified at trial and acknowledged these subsequent events. He also acknowledged that he had been offered light duty work by respondent following the FCE some time in the beginning of November. He testified that he did not return to work for respondent at that time.

Petitioner saw Dr. Heim again on November 17, 2010. Petitioner did not tell Dr. Heim about the incidents at home on November 8 and November 14. Dr. Heim acknowledged that the FCE showed less than full participation. Petitioner claimed that his back pain was worse now than it was pre-operatively. Dr. Heim reviewed the CT scan, but stated that he could not tell whether the fusion was solid. He recommended continued use of the bone stimulator. (Rx 1, Ex. 6).

Petitioner returned to see Dr. DePhillips on December 6, 2010. He reported back pain and posterior thigh pain. The CT scan was reviewed. It was unremarkable. The hardware was intact. The fusion was progressing. Physical therapy was recommended.

Petitioner returned to Dr. DePhillips on January 31, 2011. He complained that his lower back pain had worsened. He saw Dr. DePhillips again on March 21, 2011 complaining of front sided thigh pain consistent with a L3-4 nerve root distribution.

Petitioner explained that his pain had decreased six months following the surgery. Then the pain returned because of physical therapy and an event at home. (Px 6).

Dr. Heim authored an addendum report on March 25, 2011. He acknowledged the two events reported by petitioner that occurred on 11/08/10 and 11/14/10. Dr. Heim did not feel the first incident was significant enough to represent an intervening accident. However, the second event did represent and intervening event and an entirely new injury. Dr. Heim observed that Dr. Phillips' report dated March 21, 2011 noted a change in the dermatomal pattern. (Rx 1, Ex. 8). Dr. Heim authored a final addendum stating that petitioner's current symptoms are not related to the underlying event. He believed they were related to the November events that occurred at home. (Rx 1, Ex 9).

Petitioner saw Dr. DePhillips again on May 9, 2011 noting he had returned to work. A MRI was also taken showing the petitioner had disc dehydration and bulging at L3-4. Dr. DePhillips stated this was due to adjacent disc disease and not the at home event that occurred in November of 2010.

Petitioner next saw Dr. DePhillips on May 31, 2011. He complained that working up to six hours a day increased his pain. Dr. Phillips reluctantly agreed he could work six hours a day. As of July 11, 2011, Dr. DePhillips released the petitioner to an 8 hour work day.

He returned to see Dr. DePhillips in September and December of 2011. As of December 12, 2011 petitioner reported no radicular symptomatology and therefore was asked to wean off Cymbalta. He was taking Mobic and 1 to 2 Norco per day. Petitioner returned in March of 2011 where it was recommended he return for periodic pain

management. On May 15, 2012 Dr. DePhillips noted that petitioner's back pain remained unchanged. Dr. DePhillips recommended against any further surgical evaluation.

Petitioner returned to Dr. DePhillips on August 28, 2012. He reported increased pain. He denied any additional stress on his back claiming the only explanation for the increased back pain was a requirement of increased overtime.

Petitioner testified at trial that he was arrested in August of 2012 for a domestic disturbance. He testified that he broke three windows in his truck with a baseball bat. He also stated that when he was being placed under arrest the police offers knelt on his back. He told them to take it easy because he had undergone prior back surgery. It is clear from the August 28, 2012 record that petitioner did not make Dr. DePhillips aware of this event which likely caused "stress" on petitioner's back.

Petitioner presented a note from Dr. DePhillips dated December 8, 2012. It stated petitioner could work eight hours a day, 40 hours a week and eight hours on Saturday.

Dr. Heim testified at trial. He stated that following his July 22, 2009 exam, he felt petitioner had exacerbated his underlying degenerative lumbar condition as a result of an event that occurred on March 22, 2009. (Rx 1, p. 14). He acknowledged seeing the petitioner again in November of 2010. He recommended a repeat CT scan. As of January 20, 2011 the CT scan had been performed. Dr. Heim stated the fusions were intact. (Rx 1, p. 29). He also testified that he authored an addendum dated March 25, 2011. He had reviewed the FCE. He stated the petitioner could likely perform work at a higher higher level than that determined by the FCE. (Rx 1, p. 33). He also testified that the injuries of November 8, 2010 and November 14, 2010 represented new injuries which resulted in a distinct change in petitioner's symptoms. (Rx 1, p. 35). Finally, Dr. Heim authored a

April 15, 2011 note where he placed the petitioner at MMI and recommended he return to medium-light duty work. (Rx 1, p. 36).

Dr. Heim also testified regarding the healing course following a fusion. He testified that it was typical that patients would not need narcotic pain medications after a period of six months following the surgery. (Rx 1, p. 39). Petitioner still takes narcotics.

Dr. DePhillips also testified. He acknowledged that the was nothing anatomically depicted on the MRI films, X-rays or CT scans that was caused by petitioner's reported incident. (Px 7, p. 37). Dr. DePhillips also testified that he felt the November events were insignificant and resulted in temporary aggravations of pre-exisiting conditions. (Px 7, p. 37). However, he acknowledged that he has testified in the past that a petitioner hearing a "pop" could signify an annular tear in a disc. He acknowledged that such a description could represent an injury to the disc itself. He also stated that such a description could provide evidence of a causal relationship between work and an injury in certain circumstances. He acknowledged that he might be in a position to provide a causal relationship opinions on a back injury in a work setting if a worker reported falling down steps. There is no evidence in the record that any of the these things occurred in the present case.

Dr. DePhillips acknowledged that it was not until after November 2010 that the L3-4 spinal level become involved. (Px 7, p. 30). He also acknowledged that prior to the surgery L3-4 did show degenerative changes, but this level was not symptomatic. It was not rendered symptomatic until after November 2010. (Px 7, p. 31).

Petitioner concluded his testimony stating that he returned to work as a fabricator, not a welder as he had worked previously. He returned to work on May 9, 2011working

reduced hours. He returned to full capacity work as of May 28, 2011. He claimed his new job did not require him to engage in the amount of lifting required of a welder. He testified that he was earning the same pay. He was performing his job without incident.

He claims that he still takes two Vicodin per day, one in the morning and one in the evening. He periodically sees Dr. DePhillips. No other treatment is being recommended for him other than prescriptions for pain medication.

F. Is Petitioner's current condition of ill-being causally related to the injury ?

K. What temporary benefits are in dispute ?

N. Is respondent due any credit ? (TTD/TPD).

The Arbitrator finds the petitioner sustained injuries as a result of an incident at work on April 17, 2009. Petitioner underwent a two level fusion after conservative measures failed. He underwent this surgery on February 26, 2010. Thereafter, he engaged in physical therapy. The records show that he reported improvement. While his pain level reports remained high, his radicular symptomatology improved. As of June 28, 2010 petitioner reported no radicular symptoms. Those symptoms waxed and waned, but were not present on visits in October or November 1, 2010.

The completion of petitioner's recovery was evidenced by the ordering of and Dr. DePhillips acquiescence to a FCE on October 12, 2010. Petitioner gave a poor effort on the FCE.

The radicular symtoms did return, but only after petitioner was involved in the November events that occurred at home. Dr. DePhillips acknowledged first acknowledged that these events were a cause of increased symptoms in the petitionerbut that they were only temporary exacerbations or muscular strains and did not affect the status of the underlying fusion. He also explained that the adjacent segment syndrome was something that was aggravated both by the incidents at home and the fact of the underlying fusion, which was related to Petitioner's accident as alleged herein.. He also attributed the increased symptoms to petitioner's participation in physical therapy.

Indeed, petitioner had claimed that he did well six months following the surgery and then the pain returned while he participated in the physical therapy. Thereafter, he had temporary exacerbation events at He later explained in his May 2011 note that petitioner's new symptoms and L3-4 dermatomal pattern were attributable to adjacent disc disease. The November events were minor in nature according to Dr. DePhillips. This conclusion by Dr. DePhillips is credible. In fact Dr. Dephillips warned Petitoner prior to surgery that one of the likely side effects of the surgery he was undergoing was adjacent segment syndrome. It is clear that while the incidents at home in November of 2010 played some role in advancing this syndrome temporarily, the underlying fusion surgery was the main culprit in the development of the syndrome itself, and that according to the unrebutted testimony of Dr. Dephilips, the L3-4 segment would have been weakened initially by the surgery and this would lead to excarbations or symptomatic incidents with almost any activity Petitioner undertook. The law is clear in stating that the accident alleged need not be the sole cause of Petitioner's condition of ill being, but only need be "a" cause of the condition in order to render the condition compensable. The Arbitrator, based on the record as a whole, finds that the fusion surgery that Petitioner underwent was such "a " cause, and that therefore any treatment or TTD periods occasioned by the syndrome are compensable. The Arbitrator therefore orders that Respondent shall pay petitioner temporary total disability benefits of $460.14/week for 106-6/7 weeks, commencing 04/21/09 through 05/08/11, as provided in Section 8(b) of the Act and that Respondent shall pay petitioner temporary partial disability benefits of $161.05 for 2-4/7 weeks, commencing 05/19/11 through 05/27/11, as provided in Section 8(b) of the Act.

Were the medical services provided to petitioner reasonable and necessary? Has Respondent paid all appropriate charges for reasonable and necessary medical services ?

N. Is respondent due any credit ? (Medical)

Respondent is ordered to pay causally related medical bills with dates of service between April 17, 2009 and November 7, 2010 pursuant to the fee schedule. Respondent is due a credit of $283,743.91 in medical bills. Reviewing Respondents Exhibit 3 it appears those figures include a $1,100 payment for a IME. That is being excluded from the credit awarded respondent.

Petitioner submitted several medical bills. The bills from St. Mary's Hospital (Px 9), outstanding balances from Dr. DePhillips totaling $2,085.00 are denied (Px 13) and

payments for prescription medications after November 7, 2010 totaling $2,723.74 are denied (Px 14). There are bills that were submitted from a Kroger pharmacy. The Arbitrator cannot determine the dates of service on those prescriptions. To the extent the balances reflected are incurred after November 7, 2010, those bills are denied.

Respondent is ordered pay the bill from Provena St. Joseph (Px 10) pursuant to the fee schedule. The outstanding balance appears to be a balance bill and that practice is disallowed under the Act. Respondent is ordered to pay the medical bill from Joliet Radiological Services (Px 11) totaling $224.00 pursuant to the fee schedule.

Respondent is ordered to pay $646.00 of the outstanding balance to St. James Radiology (Px 12) pursuant to the fee schedule. Balances totaling $262.00 are denied (Px 12) as they reflect dates of service after November 7, 2010.

L. What is the nature and extent of the injury ?

The last comment on petitioner's permanent restrictions was from Dr. DePhillips from December of 2012. He stated petitioner could work 8 hours a day, 5 days a week and 8 hours a day on Saturday. Dr. Heim testified that petitioner could perform work beyond limitations reflected in the October 12, 2010 FCE. The only definitive statement available on petitioner's work restrictions is the last note authored by Dr. DePhillips.

Petitioner underwent a two level fusion on February 26, 2010. He completed his recovery and returned to work. He continues to take Narcotic pain medications. He claims he continues to have aches and pains. However, he still demonstrated the physical ability to break three car windows and become involved in an altercation with his partner such that the police were called upon to arrest him while kneeling on his back. Given this, petitioner's demonstrated ability to return to work, generous work restrictions

allowing petitioner to work beyond a 40 hour work week and the invalid FCE which undercuts petitioner's claims of disability, the Arbitrator finds petitioner has suffered impairment of 30% loss of use of the whole person pursuant to section 8(d)(2).

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Taranne Becker,

Petitioner,

14IWCC0038

vs.

NO: 10 WC 14532

Decatur Memorial Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability and medical expenses and being advised of the facts and law, reverses the Decision of the Arbitrator. In so doing, the Commission finds discrepancies in the evidentiary record that leads it to conclude Petitioner failed to prove that her injuries arose out of and in the course of her employment.

The first discrepancy relates to the purported onset date of accident. Though Petitioner did not provide a definite onset date, she twice testified that the onset of her bilateral carpal tunnel syndrome occurred either in late 2008 or early 2009. Only two explicit references to when Petitioner began experiencing her bilateral carpal tunnel syndromes were found in Petitioner's medical records. The first record, authored by Petitioner's primary care physician, Dr. Newcome, on March 6, 2009, recorded Petitioner experiencing bilateral tingling of her hands, numbness to her fingers and thumbs and "electric shocks" from her elbows to her hands that had been present for two years. The second record was made less than two weeks later when Petitioner presented for an EMG/NCV study on March 17, 2009. The clinical history that was recorded at the time of the study noted Petitioner presented with a one to two year history of tingling, numbness and achy pain in her upper extremities. A third record, a record review report written by Dr. Greene, a physician retained by Petitioner, noted Petitioner's symptoms presented in 2007. Whenever the onset date, or more appropriate, timeframe, of Petitioner's carpal tunnel

syndrome symptoms is found in her medical records, it is consistently a time earlier than to when Petitioner testified it occurred. Given this, the Commission does not find Petitioner's testimony to be as credible as did the arbitrator and finds Petitioner's carpal tunnel syndrome symptoms presented themselves at time earlier that Petitioner claims.

The second apparent discrepancy relates to the claim that her carpal tunnel syndrome symptoms being exacerbated by her work activities. Petitioner initially testified that she experienced her hands cramping, of experiencing a snapping feeling inside her palm and of her fingers going numb when she typed. She testified further that she did not experience these incidents outside of work. Again, Petitioner's medical records conflict with her testimony. Petitioner's March 6, 2009, visit to Dr. Newcome resulted in him recording that her symptoms were made worse with computer work, indicating that she was also symptomatic when not engaged in computer work. On May 15, 2009, Dr. Weber, with whom Petitioner eventually underwent bilateral carpal tunnel release, recorded a history of Petitioner's pain being present when she worked, when she drove and at night as she slept. Dr. Weber, on November 17, 2009, noted Petitioner's pain was worse at night and when driving. Dr. Greene, the physician who performed the record review, also noted Petitioner's records indicate her pain was worse when both typing and driving. The Commission finds the record mixed as to whether Petitioner's work actually exacerbated her carpal tunnel syndrome symptoms as Petitioner stated to Dr. Newcome that it did, but, to Dr. Weber, with whom she had treated with more recently, she was recorded being more symptomatic outside the workplace. It is this record, of Petitioner being more symptomatic when she drove and at night undercuts her claim that she was not symptomatic outside of her work environment. Again, the Commission does not find Petitioner's testimony to be as credible as did the arbitrator.

Lastly, the Commission questions the finding that Dr. Greene was credible with respect to his assessment that Petitioner's work activities aggravated her symptoms. The Commission notes Dr. Greene had no personal interaction with Petitioner but, nevertheless was aware, without explaining how, that she performed 90% keyboarding over a 10-hour and, upon reviewing her job description, stated Petitioner was "required to lift, push, pull, 5-20 pound [sic] frequently, with constant repetitive motion of arms, hands and wrists [and] is also required to use precise hand and arm positions." It is unclear to the Commission how Dr. Greene became aware of the extent of Petitioner's keyboarding or if he knew which of the activities in her job description, if any, she actually performed and, if so, how often. Without being provided further information, the Commission is reluctant to find Dr. Greene's assessment to be sufficiently credible as to rely upon it.

Petitioner made statements at her arbitration hearing that in conflict with statements she made to her treating physicians concerning the onset of her carpal tunnel syndrome symptoms and what activities aggravate said symptoms. Her testimony was that she became symptomatic in late 2008 or early 2009 and also that she only experienced her symptoms while at work. Her medical records document her claiming the onset of her carpal tunnel syndrome symptoms, at the latest, in early 2008, with others noting the onset occurred in 2007. Her medical records also document that she was not asymptomatic outside of her workplace as she claimed. But for these discrepancies, the Commission would have found Petitioner to be credible. As such, however, the Commission does not and finds Petitioner failed to prove accident as contemplated in the

14IWCC0038

Act. Accordingly, all benefits awarded under the June 14, 2013, Decision of the Arbitrator are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that all benefits awarded to Petitioner pursuant to the June 14, 2013, Decision of the Arbitrator are vacated as Petitioner failed to prove her accidental injuries arose out of and in the course of her employment.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
KWL/mav
O: 12/5/13
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0038

BECKER, TARANNE M
Employee/Petitioner

Case# 10WC014532

DECATUR MEMORIAL HOSPITAL
Employer/Respondent

On 6/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0834 KANOSKI BRESNEY
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OFSANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0038

Taranne M. Becker
Employee/Petitioner

v.

Decatur Memorial Hospital
Employer/Respondent

Case # 10 WC 14532

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on May 13, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **March 17, 2009** , Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$21,980.48**; the average weekly wage was **$422.71**.

On the date of accident, Petitioner was **37** years of age, married with **one** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** not paid all appropriate charges for all reasonable and necessary medical services.

Respondent is entitled to a credit of **$774.68** under Section 8(j) of the Act for disability payments made.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $281.81/week for 5 5/7 weeks, commencing 7/27/09 through 8/13/09 and 12/14/09 through 1/6/10, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $22,491.40, subject to the medical fee schedules as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be entitled to 8J credit for payments by Consociate, the employer sponsored health insurance.

Respondent shall pay Petitioner permanent partial disability benefits of $253.63/week for 51.25 weeks, because the injuries sustained caused 12.5% loss of use of each hand, as provided in Section 8(e) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dyl McCarthy
Signature of Arbitrator

Date June 10, 2013

JUN 14 2013

In considering the disputed issues in this claim, the Arbitrator considers the following evidence:

Petitioner testified that she was employed as a unit secretary in the surgery department of Decatur Memorial Hospital from July 2001 through her date of accident in 2009. Petitioner testified that her job keyboarding 80 to 90 percent of her day, and she was also involved in answering phones. Petitioner testified that she normally worked 10 hours per day and 40 hours per week, but acknowledged that the wage information submitted as Respondent's Exhibit 2 was probably a correct statement of her hours worked during the year prior to her date of manifestation. Those records showed that the Petitioner worked most often between 25 to 35 hours per week. Petitioner testified that in the course of her work activities in early 2009, she began to experience pain, numbness and tingling in her hands. She testified that these symptoms were brought on by the repetitive work activities of her job and were relieved when she was off work for a few days. She acknowledged that her keyboarding activities were not like those of a typist doing transcriptions, describing her keyboarding as involving five minute projects where she used both the keyboard and mouse.

Petitioner sought medical care first from her family practitioner, Dr. Kristin Newcombe, on March 6, 2009. (Pet. Ex. 3, pp. 88-89) Treatment notes for that date indicate that Petitioner presented with complaints of bilateral hand tingling with numbness in her 4th and 5th fingers of both hands and thumbs, and feelings of electric shocks from her elbow to her hands. Notes indicate that Petitioner complained of pain when making a fist and difficulty holding objects as her hands felt weak. Petitioner reported to the doctor that she works as a unit secretary and that her symptoms were worsened by computer work. The history indicates that her symptoms have been present for 2 years but had become worse over the previous 4 months. On examination, Dr. Newcombe noted no thenar wasting but found positive Phalen's and Tinel's signs. Petitioner was diagnosed with paresthesias and bilateral EMG/NCV tests were ordered. Petitioner underwent that testing on March 17, 2009, by Dr. Zaheer Ahmed, at Decatur Memorial Hospital. (Pet. Ex. 2, p. 409) In the history provided for that examination, Petitioner reported a 1-2 year history of tingling, numbness and achy pain involving her upper extremities which would often awaken her at night. Examination showed mild weakness in her grips bilaterally. Petitioner reported tingling to sensory stimuli. The electrodiagnostic study was abnormal, showing evidence of median nerve compression at both wrists consistent with bilateral carpal tunnel syndrome. Dr. Ahmed noted that Petitioner would benefit from surgical evaluation.

Petitioner was then referred to Dr. Stephen Weber whom she saw initially on May 15, 2009. (Pet. Ex. 1, pp. 2-4) Petitioner gave a history of numbness, tingling and pain predominantly in her third, fourth and fifth fingers but also described numbness in her thumb. She reported that these sensations would awaken her at night and would also bother her at work where she did a lot of keyboarding. Petitioner also described pain while driving. She reported that her symptoms were worse in her left hand. Dr. Weber noted that the NCV study showed evidence of bilateral carpal tunnel syndrome without ulnar involvement. On examination, Dr. Weber noted that Petitioner had a positive Tinel's sign in her left median nerve. Dr. Weber diagnosed Petitioner with carpal tunnel syndrome and recommended surgery on her left hand first. Petitioner underwent a left carpal tunnel release on July 27, 2009 at Decatur Memorial Hospital. (Pet. Ex. 1, p. 13) Petitioner was taken off work at the time of surgery. (Pet. Ex. 1, p. 11) Petitioner followed up with Dr. Weber on August 21, 2009, and he noted she was doing well though she could not quite touch her thumb to her small finger. (Pet. Ex. 1, pp. 16) Her numbness and pain was relieved and Dr. Weber recommended that she be seen in physical therapy for hand exercises. Petitioner was released to return to work on August 24, 2009. (Pet. Ex. 1, p. 17) Petitioner returned to Dr. Weber on November 17, 2009, reporting that her symptoms had resolved in her left hand but that her right hand symptoms were worsening. (Pet. Ex. 1, pp. 19-21) Petitioner reported that her symptoms were in her first few digits and a little bit in the fourth. Petitioner reported dropping things and that her pain was

worse at night and while driving. Dr. Weber opined that the Petitioner would do well with a right carpal tunnel release as she had on the left, and scheduled surgery. Petitioner underwent a right carpal tunnel release on December 14, 2009 at Decatur Memorial Hospital. (Pet. Ex. 1, p. 29) Petitioner was taken off work at the time of surgery. (Pet. Ex. 1, p. 26) Petitioner returned to Dr. Weber in followup on December 22, 2009, reporting that she felt that she was recovering quicker from this surgery than on the left side. (Pet. Ex. 1, pp. 31-33) Dr. Weber released her from care to return as needed. Petitioner was released to return to work on January 5, 2010. (Pet. Ex. 1, p. 34)

Petitioner offered the expert testimony of Dr. Mark Greene by evidence deposition. (Pet. Ex. 4) Dr. Greene testified that he performed a records review of the records outlined above as well as the Petitioner's job description. (Pet. Ex. 4, pp. 7-8) Dr. Greene testified that the medical records confirmed that the Petitioner was suffering from median neuropathy in her upper extremities and that the treatment rendered was appropriate. (Pet. Ex. 4, p. 9) Based upon the job description and a further hypothetical question regarding the Petitioner's work activities, Dr. Greene opined that the Petitioner's work activities were an aggravating factor in the development of her condition. (Pet. Ex. 4, pp. 9-10) He seemed to place a lot of importance in the fact that her symptoms occurred while she was at work, which is the same thing she reported to Dr. Newcome at her first treatment visit. (Pet. Ex. 4, p. 10) Dr. Greene opined that it has been shown that repetitive use of the hands can aggravate a median neuropathy. (Pet. Ex. 4, pp. 10-11)

Respondent offered the evidence deposition of Dr. Craig Phillips who had performed a records review for Respondent's worker's compensation carrier. (Resp. Ex. 4, p. 8) Dr. Phillips opined that the Petitioner's work activities, based upon the written job description, did not cause or aggravate her carpal tunnel syndrome. (Resp. Ex. 4, p. 12) Dr. Phillips testified that though in the past it was accepted that typing activities as those pursued by the Petitioner were a cause of carpal tunnel syndrome, current research disputed that conclusion. (Resp. Ex. 4, p. 13-14) Dr. Phillips acknowledged though that the Petitioner's other risk factors such as obesity and smoking were mild and would not put her at direct risk for development of the condition. (Resp. Ex. 4, p. 16-17) Dr. Phillips speculated that Petitioner had some anatomical abnormality to explain her getting carpal tunnel syndrome. He said that her carpal canals were congenitally small, gleaning that from the operative reports. (Resp. Ex. 4, pp. 19,20, 30) Dr. Phillips said that carpal tunnel was related to heavy activities involving force and posture. Dr. Phillips also said that tenosynovitis could develop as a result of less strenuous activities, and also cause carpal tunnel. He said this could happen when a person notes symptoms such as limited motion, pain and swelling which abate when they change their activities, only to have the symptoms return when the same activities are resumed. (Resp. Ex. 4, p. 16) He did not give an explanation as to why the Petitioner reported an increase in symptoms when performing her job which abated when she left the job, nor why keyboarding for 80 to 90 % of the work day could not cause tenosynovitis.

The Arbitrator notes that among the documents provided in Respondent's Exhibit 1 is a document entitled "Position Description". On page 3 of that document under the "Physical Demands" of the job it is noted that "The employee's duties include constant repetitive motion of the arms, hands and wrists".

Petitioner testified that she continues to experience an occasional cramping pain in her hands. She testified that once or twice each work day she has to pull away from the keyboard due to cramping pain. She also testified that her grip strength is weaker and she has difficulty opening jars and stirring food.

Based upon the foregoing facts, the Arbitrator makes the following findings on the disputed issues:

1. **Accident and causation:** Based upon the Petitioner's credible testimony regarding her work activities and the onset and exacerbation of pain and numbness in her hands associated with those activities, the more credible opinion of Dr. Greene and the corroboration in the Respondent's job description that Petitioner's job requires constant repetitive motion of her hands and wrists, the Arbitrator finds that the Petitioner's bilateral carpal tunnel syndrome is causally related to her repetitive work activities for Respondent.
2. **Temporary total disability:** Respondent did not dispute the duration of temporary total disability but only its causal relationship to the Petitioner's work activities. Having found accident and causation in Petitioner's favor, the Arbitrator awards 5 5/7 weeks of TTD for the periods claimed by Petitioner.
3. **Medical expenses:** Based upon the Petitioner's testimony, Dr. Greene's opinion and the medical records and bills submitted in to evidence, the Arbitrator finds the medical bills submitted to be reasonable and necessary and causally related to the Petitioner's work activities for Respondent. Respondent is ordered to pay the outstanding bills subject to the medical fee schedules, and reimburse Petitioner's husband's health insurance for payments made on said bills. Respondent will receive credit for payments made by Consociate subject to the obligation in Section 8J to hold Petitioner harmless from any claim for reimbursement.
4. **Nature and extent:** The Petitioner was diagnosed with mild carpal tunnel syndrome bilaterally, based upon her nerve conduction studies. (Pet. Ex. 4) Dr. Weber provided very little post operative treatment, and the Petitioner reported that she was doing very well when released from care on December 22, 2010. She has performed her regular job without treatment since that date. She does report symptoms, referenced above. As a result of her accidental injuries, the Arbitrator finds permanent partial impairment to the extent of 12.5% of each of the Petitioner's hands.

STATE OF ILLINOIS	)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENNIS FRETTS,

Petitioner,

14IWCC0039

vs.

NO: 09 WC 16718

ABF FREIGHT SYSTEMS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent of permanent disability, penalties and attorney fees, maintenance benefits, and vocational rehabilitation, and being advised of the facts and law, clarifies and corrects the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On page 14 of Arbitrator's decision, the Commission corrects the Arbitrator's statements with regard to Petitioner's job search. On page 14, paragraph one, sentences seven and eight, the Commission strikes "Neither was there evidence presented of a self-directed search. The Arbitrator has not been presented with any evidence of a search, diligent or not;" To the contrary, a review of the record reveals Petitioner did submit a set of job search records, PX17. However, in so finding, the Commission affirms and adopts the Arbitrator's conclusion that Petitioner failed to present evidence of a diligent job search. The documents contained within PX17 fail to support Petitioner's testimony that he engaged in a diligent job search. A review of the documents within PX17 reveals that none of the job search records submitted by Petitioner pertained to any actual posted job openings, and instead it appears Petitioner merely called or walked into businesses without identifying opening, and merely inquired if the businesses were hiring. The records submitted fail to indicate that Petitioner completed any job applications, submitted any resumes, and little if any follow up on any of his alleged inquiries.

On page 15, paragraph one, sentence two of the Arbitrator's decision, the Commission strikes "25% of the right arm or," and finds that because Petitioner's undisputed work injury involves his shoulder, the permanency is properly awarded under Section 8(d)2 of the Act, and Petitioner has established permanent partial disability to the extent of 12.65% loss of use of the person as a whole. See Will County Forest Preserve District v. IWCC, 2012 Ill.App.3d 110077WC, 970 N.E. 2d 16, 361 Ill.Dec. 16, where Appellate Court held that the shoulder is distinct from the arm and that permanency awards in such cases should be made pursuant to Section 8(d)(2) of the Act rather than Section 8(e).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 8, 2012, as corrected and clarified herein, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $693.98 per week for a period of 53-4/7 weeks, for the period of December 7, 2007 through December 15, 2008, and the sum of $841.77 per week for a period of 54-2/7 weeks, for the period of May 12, 2009 through May 25, 2010, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $624.58 per week for a period of 63.25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use to the person as a whole to the extent of 12.65%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $17,683.48 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties and attorney's fees is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury, including Respondent's payment of $98,158.06 for temporary total disability benefits paid, $7,045.68 for temporary partial disability benefits paid, and $10,512.60 for a permanent partial disability advance.

14IWCC0039

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
KWL/kmt
O- 12/17/13
42

Kevin W. Lamborn

Thomas J. Tyrrell

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0039

FRETTS, DENNIS
Employee/Petitioner

Case# **09WC016718**

09WC026492

ABF FREIGHT SYSTEMS INC
Employer/Respondent

On 11/8/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2965 KEEFE CAMPBELL & ASSOC LLC
JOSEPH F D'AMATO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0039

Dennis Fretts
Employee/Petitioner

Case # 09 WC 16718

v.

Consolidated Case: 09 WC 26492

ABF Freight Systems, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on August 27, 2012. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Workers' Compensation fraud, ppd advance**

14IWCC0039

FINDINGS

On 5/8/09, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $28,991.22; the average weekly wage was $1,262.65.

On the date of accident, Petitioner was 52 years of age, *single* with 0 dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ 98,158.06 for TTD benefits paid, $7,045.68 for TPD benefits paid, $0.00 for maintenance benefits paid to date and $10,512.60 for a PPD advance for a total of $115,715.34.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $693.98 per week for 53 &4/7 weeks commencing December 7, 2007 through December 15, 2008, as provide in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $841.77/week for 54 & 2/7 weeks, commencing May 12, 2009 through May 25, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay to the medical service providers reasonable and necessary medical services up to $17,683.48 or the balance of the expenses, pursuant to this decision, as provided in Section 8(a) of the Act.

Respondent shall have credit for any and all medical services, temporary total disability and temporary permanent disability previously paid pursuant to sections 8(a) and 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $624.58 per week for 63.25 weeks because of injuries sustained caused 25% loss of the right arm as provided in Section 8(e) of the Act or 12.65% loss of the whole person, a provided by Section 8(d)(2) of the Act.

No penalties or attorney's fees are awarded.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of

payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

November 7, 2012

NOV - 8 2012

14IWCC0039

The disputed issues in the matter of 09 WC 16718 are: 1) causal connection; 2) temporary total disability; 3) temporary permanent disability; 4) medical bill payments; 5) penalties; 6) attorney's fees; 7) nature and extent; and 8) determination of workers' compensation fraud. *See,* AX1

The disputed issues in the matter of 09 WC 26492 are: 1) causal connection; 2) temporary total disability; 3) temporary permanent disability; 4) medical bill payments; 5) penalties; 6) attorney's fees; 7) nature and extent; 8) determination of workers' compensation fraud; 9) wage differential period; 10) maintenance; and 11) permanent partial advances. *See,* AX2.

In case number 09 WC 16718, the date of accident was December 1, 2007. Petitioner testified he was employed by ABF Freight Systems (hereinafter referred to as "Respondent") on December 1, 2007, and May 8, 2009, as a truck driver. Petitioner stated he drove semi-point double trailers loaded with freight from Chicago Heights to other terminals around the country. Petitioner also testified that the other physical aspects of the job included dropping, hooking and setting trailers. He noted that his job did not include loading or unloading the trailers. *See,* Tr. at 24-25. On December 1, 2007, Petitioner testified that it was an icy day and he slipped attempting to get into his truck. His right arm was forced into a forward flexed position as he fell. He testified that he felt a pulling sensation and pain in his right shoulder.

On December 10, 2007, he had x-rays taken at Concentra Medical Center which showed osteopenia and a degenerative spur formation. On December 28, 2007, Petitioner underwent an MRI study for the right shoulder at Provena Health Center which showed severe supraspinatus tendinosis with a superimposed low grade partial-thickness tear of the mid-fibers; moderately severe acromioclavicular osteoarthritis; and severe glenohumeral osteoarthrosis. There was an abnormal signal in the anterior labrum suspicious of a tear and the technician also suspected a degenerative condition.

On January 12, 2008, Dr. Corcoran diagnosed the petitioner as having right shoulder osteoarthritis, rotator cuff tendonitis and impingement syndrome. Petitioner was taken off work for four (4) weeks and prescribed physical therapy ("PT") three (3) times per week for four (4) weeks. Dr. Corcoran also prescribed 200 mgs of Celebrex and administered an injection of Kenalog and Marcaine.

On January 15, 2008, Petitioner started PT and continued PT until March 6, 2008, with the

doctor stating that Petitioner had an exacerbation of existing glenohumeral arthropathy and also had impingement syndrome. On March 31, 2008, Petitioner underwent a right shoulder arthroscopy; a chondroplasty of glenoid and humerous; an arthroscopic Bankart repair; debridement of an undersurface rotator cuff tear; a subacromial decompression consisting of CA ligament excision; and an acromioplasty with arthroscopic distal clavicle re-section. He was placed on PT and taken off of work until further notice.

On August 20, 2008, Petitioner started a work conditioning assessment at AthletiCo and on September 29, 2008, the therapist noted that he was reporting right shoulder pain. It was noted that scar tissue was limiting his range of motion ("ROM") and tissue massage was prescribed through September of 2008; and chiropractic treatment was prescribed through October 2, 2008.

On November 4, 2008, Petitioner completed a valid functional assessment at ATI Physical Therapy and demonstrated an ability to function at the medium to heavy physical demand level. It should be noted that Petitioner's truck driving occupation was described as requiring a medium physical demand level.

On November 11, 2008, Dr. Corcoran noted this demand level and stated that Petitioner had some concerns about whether he could work overhead and move dollies to pull dual trailers. Upon physical examination, the doctor observed that Petitioner lacked ten (10) degrees of forward flexion and external rotation. He continued Petitioner off of work for another four (4) weeks then on December 3, 2008, released him to work with the following restrictions: 1) no overhead lifting; 2) ground level work only; and 3) no lifting over thirty (30) pounds.

On December 15, 2008, Dr. Corcoran commented on Petitioner lack of ROM, i.e. twenty (20) degrees of forward flexion on the right and fifteen (15) degrees of external rotation on the right side compared to the left. Petitioner was released to return to work in a full duty capacity.

Petitioner continued treating with Dr. Corcoran, i.e. having a cortisone shot on January 26, 2009 and upon a March 6, 2009 examination, Dr. Corcoran observed that the petitioner lacked twenty (20) degrees of forward flexion and ninety (90) degrees of abduction and fifteen (15) degrees of external rotation. He stated that Petitioner had lost some ROM and was going to have some chronic disability and diffused degenerative changes, exacerbated by his work injury.

On May 8 2009, Petitioner had a second accident. He testified that he was at work, hooking up a double trailer, pulling a gear chain to connect to the trailer, when he jarred his right shoulder. His relevant duties as an over-the-road driver, at the time of this accident, consisted of (1) driving a semi-point double trailer; (2) being able to hook and unhook an approximately three hundred (300) pound converter gear; (3) being able to maneuver it which according to one of Respondent's witness, took approximately five to ten pounds of force for five seconds, and (4) being skilled in driving a double tractor-trailer rig.

On May 12, 2009, Petitioner went to Concentra Medical Centers and was seen by Dr. Knight who ordered an MRI; then released him to return to work with restrictions of no lifting, pulling or pushing; and limited use to the right arm. Respondent accommodated Petitioner's restrictions.

On May 22, 2009, Petitioner underwent an MRI of the right shoulder at Provena St. Mary's Hospital which showed severe, chronic-appearing degenerative changes of the glenohumeral joint with remodeling of the articular surface of the humeral head; and glenoid consistent with a chronic labrum tear. A full-thickness tear of the supraspinatus tendon was noted with a possible loose body in the anterior aspect of the joint space. The supraspinatus tendon finding appeared to be new when compared to diagnostic testing performed on December 28, 2007. The glenoid labrum changes appeared more advanced. On May 27, 2009, Dr. Knight released Petitioner to return to work in a full duty capacity, without restrictions.

On May 29, 2009, Petitioner was seen by Dr. Anthony Romeo at Midwest Orthopaedics. His

diagnosis was a possible acute right shoulder rotator cuff tear with an underlying diagnosis of glenohumeral osteoarthritis. Dr. Romeo noted Petitioner's original work injury to the right shoulder on December 1, 2007 and his recent work injury to his shoulder on May 8, 2009. He noted that the petitioner now had increased symptoms of pain and a new MRI that revealed obvious degenerative changes of the glenohumeral joint; and a full-thickness tear of the supraspinatus tendon; which was distinct from his previous MRI. He restricted Petitioner to sedentary duty and no work above shoulder level; maximum lifting of ten pounds at or below waist level; and he recommended surgery for rotator cuff repair.

On July 31, 2009, Petitioner underwent a second right shoulder surgery performed by Dr. Romeo at Rush Oak Park Hospital. The operation performed was a right shoulder arthroscopy debridement with a capsular release. Petitioner testified he attended PT and eventually underwent a functional capacity evaluation ("FCE") in April of 2010. *See,* Tr. at 30-33. After reviewing the results of the FCE, Dr. Romeo returned Petitioner to work with the following restrictions: medium duty capacity from floor to waist, light medium capacity from waist to shoulder and light duty above the shoulder level on the right; and he ordered a floor to waist lifting restriction of fifty (50) pounds; from waist to shoulder of thirty-five (35) pounds; and above the shoulder with no more than twenty (20) pounds. Dr. Romeo felt that the restrictions were permanent. *See,* RX14, pg 17.

On August 12, 2009, Dr. Romero prescribed aqua therapy for three months and in October, 2009 he ordered six (6) weeks of PT. In December of 2009, Dr. Romero prescribed PT to treat the capsular release and in January of 2010, ordered Petitioner to be off work for another six (6) weeks for more PT.

On April 8, 2010, Petitioner took an FCE at ATI which was deemed valid however; the petitioner consistently reported anterior and posterior shoulder pain with lifting. The therapist recommended a course of work hardening which the doctor ordered. From April 19, 2010 through May 14, 2010, Petitioner attended a course of work hardening.

On May 26, 2010, Petitioner was released to return to work with the following restrictions:

1) light duty above the shoulder level and lifting a maximum of twenty (20) pounds occasionally and not more than ten (10) pounds frequently; 2) medium to light work from waist to shoulder, lifting a maximum of thirty-five (35) pounds occasionally and not more than twenty (20) pounds frequently; and 3) medium work from floor to waist, lifting no more than a maximum fifty (50) pounds occasionally and not more than twenty-five (25) pounds frequently. Dr. Romero considered petitioner to be at maximum medical improvement ("MMI") and discharged him from his care.

On July 26, 2010, Petitioner presented to Dr. William Vitello, at Respondent's request, for an independent medical examination ("IME"). A report was generated by the doctor, dated July 28, 2010, in which he noted that at the time of examination, Petitioner's complaints were right shoulder pain, lack of ROM and difficulty lifting. There was no symptom magnification and based on the doctor's view of the medical records, his diagnosis of Petitioner's condition was moderate to severe right shoulder glenohumeral arthritis. Dr. Vitello did not believe that the petitioner could work in a full duty capacity, at that time, and he concurred with the permanent work restrictions imposed by Dr. Romero. He went on to state that he agreed with Petitioner's medical treatment and thought that it was reasonable and necessary and that Petitioner's current condition of ill-being was causally related to both the December 1, 2007 and May 8, 2009 accidents, based on a reasonable degree of medical and surgical certainty. And that Petitioner had some degree of pre-existing glenohumeral arthritis, prior to the first accident. *See*, RX28.

On August 13, 2010, Petitioner met with David Patsavas, a certified vocational rehabilitation consultant, at the request of his counsel. A summary of his report is as follows:

> Based on Mr. Fretts' overall transferable skills, prior work history, completion of a high school diploma, and being released to return to work by his treating physician, it is this consultant's professional opinion as a certified rehabilitation consultant that he is a candidate for Vocational Rehabilitation Services. Mr. Fretts could benefit from job readiness and job seeking skills coordination through a certified rehabilitation consultant.

> Additional exploration such as educational training and/or on-the-job training, as well as direct job placement services would be beneficial for Mr. Fretts' return back to gainful employment. It is this consultant's professional opinion that Mr. Fretts' potential earning at this time would be between $10.00 to $15.00 an hour.

On February 2, 2012, Dr. Mash testified, at Respondent's request, that he had performed a records review and had also reviewed surveillance video of the petitioner and he opined that Mr. Fretts is capable of exceeding the restrictions placed upon him by Dr. Romeo. On cross examination, Dr. Mash admitted he did not know what type of truck Mr. Fretts drove for Respondent. He admitted that lifting weights and staying active is helpful after suffering a shoulder injury. He agreed that Dr. Romeo is well respected in the field of shoulder surgery. *See,* RX14 pgs. 25-29.

On February 27, 2012, the parties took the deposition of Ms. Mary Szczepanski, a certified case manager, over Petitioner's attorney's objection that Ms. Szczepanski is not a certified vocational rehabilitation counselor and is not qualified pursuant to section 8(a) of the Workers' Compensation Act, (the "Act"). The case manager rendered a vocational opinion and produced a report regarding the petitioner.

At trial, Petitioner testified that while working, he had stayed within his prescribed restrictions and that he had attempted to return to work with Respondent but that even driving a straight truck and a pick-up truck proved difficult. He testified that he had only worked a few days for Mr. Havner and denied requesting more jobs from Havner Enterprises. He testified that agents of Respondent told him, after his release from Dr. Romeo, that Respondent would not take him back. *See,* Tr. Pgs. 37-40, 162.

Respondent called four witnesses, Christopher Havner, Keith Coffel, Dean Gluth and Stephen Evener.

Christopher Havner's testimony

Mr. Havner testified that he is the owner of Havner Enterprises ("Havner") and that he paid Mr. Fretts $500.00 to drive a flat-bed truck of products to Louisiana and $700.00 to drive a pick-up truck to the East Coast. *See,* Tr. Pg. 182. The petitioner testified that to test whether his shoulder was in condition to return to work, he drove a trip for Havner on August 11, 2011; and it took him twenty (20) hours to drive from Illinois to Louisiana. He further testified that he was under permanent restrictions imposed by Dr. Romeo when he made this trip; that the trip aggravated his shoulder condition; that he was paid $500.00 for making the trip; and that he was still collecting temporary total disability ("TTD") from Respondent at that time, i.e. $800.00 in TTD payments. The petitioner further testified that two months later he drove a second trip for Havner Enterprises in October of 2011, traveling from Illinois to several states on the East Coast in a pick-up truck to deliver lawn mowers; and that he was paid $700.00 for this trip. Mr. Havner's testimony confirmed these trips and the payments.

Keith Coffel testimony

Mr. Coffel testified that he has known Mr. Fretts for twenty (20) years and met him at the gym and that Mr. Fretts told him about the two trips he took for Mr. Havner. Mr. Coffel testified that he warned Petitioner that he might get in trouble for working while receiving TTD benefits. Mr. Fretts told Mr. Coffel that he didn't know if he was going to be able to return to work for Respondent as it depended on the mobility of his shoulder after rehabilitation and his doctor's restrictions. Mr. Coffel testified that he never saw Petitioner lifting weights with his shoulders. *See,* Tr. Pgs. 204-214.

Dean Gluth's testimony

On January 5, 2011, Dean Gluth from Infomax Investigations entered Riverside Health Facility, a private gym in Bourbonnais, Illinois with a video camera and captured video footage of Petitioner exercising and lifting weights. *See,* Tr. Pgs. 249-253. Petitioner was not aware that he was being videotaped. *Id.* pg. 99. Mr. Gluth testified he stood approximately twenty (20) feet from Petitioner while Petitioner was lifting weights and pretended to exercise while conducting surveillance on Petitioner. *See,* Tr. pg. 256. Mr.

Mr. Gluth stated he captured video surveillance using what he termed a "covert camera encased in an ID badge lanyard." *Id.* at 254. This video footage, labeled as Respondent's Exhibit 6, was shown several times during trial and claimant admitted on cross-examination, that the video accurately depicted him exercising at that location on January 5, 2011. *Id.* pgs. 87-88. The parties essentially agreed Petitioner was lifting weights at the gym on January 5, 2011; and they agreed that he was engaged in the following exercises: dumbbell bench presses, push-ups and incline dumbbell bench presses. *See,* Tr. pgs. 83-107. The Arbitrator viewed the video and makes the following factual determinations regarding the movements captured:

- dumbbell bench press: Petitioner was laying on a flat bench pressing dumbbells from his chest outward, using his arms, shoulder and chest for at least eleven (11) repetitions at a time;
- push-ups: Petitioner was in a prone position, face down to the floor, pushing his body weight up and lowering it, using his arms, shoulders and chest for at least 10 repetitions at a time; and
- incline dumbbell bench press: Petitioner was seated on an inclined bench pushing dumbbells from chest movement straight out from his chest using his chest, arms and shoulders for at least eleven (11) repetitions at a time.

The Arbitrator did not discern any evidence of claimant being in discomfort while engaging in the aforementioned activities. The Arbitrator further witnessed Petitioner changing dumbbells frequently, opting for larger and presumably heavier weights during each new set of repetitions.

Petitioner testified none of the weights he lifted on January 5, 2011, were greater than twenty (20) pounds. *See,* Tr. pg. 86. Claimant also testified that at times, he could not recall how much weight he was lifting. *Id.* at 113.

Mr. Gluth testified that the dumbbells Petitioner lifted while doing dumbbell bench presses ranged from forty (40) to fifty-five (55) pounds. *Id.* pgs. 261-272. He testified that he wrote down the weights of the dumbbells lifted by claimant in a spiral notebook while conducting

surveillance. *Id.* at 256-257. At times, Mr. Gluth is visible on the video, examining the dumbbells used by Petitioner at the conclusion of various exercises. *Id.* pgs. 266-267.

On the particular issue of how much weight petitioner was lifting, the Arbitrator finds the testimony of Mr. Gluth to be more reliable than the testimony of claimant. Mr. Gluth's sole purpose for being in the gym was to record Petitioner's activities, while Petitioner's sole focus, presumably, was exercising and lifting weights. Additionally, Mr. Gluth can be seen in Respondent's Exhibit 6, recording the weight of the dumbbells used by claimant. The Arbitrator finds Mr. Gluth's testimony to be more credible and accurate and further finds claimant lifted weights ranging from 40 to 55 pounds in the gym on January 5, 2011. The Arbitrator notes the evidence of claimant lifting dumbbells weighing between 40 and 55 pounds is relevant to the nature and extent of his injuries however it is also noted that the petitioner did not lift the weights overhead but in a lateral motion; pushing out from his chest.

On cross-examination, Mr. Gluth testified that he was not concerned about whether he was violating the rules of the gym by taking covert video on the premises. He could not see the weight printed on the dumbbells while Mr. Fretts was working out, rather, he had to get up and go to the rack where the weights were placed after Mr. Fretts finished exercising; which was some distance away. He admitted it would have been a problem if the people running the gym had seen him videotaping. And he testified that as a private investigator, he is not allowed to obtain video of a person in a tanning salon, hotel room, bathroom, or locker room which the Arbitrator notes that the gym is none of these. *See,* Tr. pgs. 290-309.

Stephen Evener's testimony

Mr. Evener testified that he is currently a supervisor for Respondent, but was a dispatcher at the time of Petitioner's accidents. On direct examination he testified that the job of an over-the-road truck driver required "minute positioning of equipment" that entailed pushing a three hundred pound object. It also requires over-the-head lifting. He later testified that a driver might have to push the converter gear for five to seven (5-7) seconds, and that the gearbox weighs three hundred (300) pounds. He testified that a driver might

need to exert a brief hundred pound pull to pull down an empty trailer door and that this action would require reaching up to grab a fabric strip and pulling down. *See,* Tr.pgs. 323-330.

On cross-examination, Mr. Evener testified he had never driven a double trailer truck and that pushing the converter gear was the hardest part of the job; and that that maneuver is not depicted in the job description video submitted into evidence by the respondent. He testified that moving the converter gear could put the worker at risk of injury and that getting into and out of the truck requires having the right hand extended over one's head; and holding onto a bar on the right side of the driver's door. He stated that the job requires hooking and unhooking overhead cables, which requires some force. He further testified that if someone can't get their hands above shoulder level, that would be a problem in terms of performing the job. He testified that the converter gear weighed approximately five hundred pounds and that it might actually be three thousand pounds or greater. He admitted it would take one to two hundred pounds of exertion to push the converter gear and that climbing in and out of a tractor could occur up to twenty (20) or thirty (30) times on an average work shift. *See,* Tr. Pgs. 349-371.

On rebuttal, Mr. Fretts testified that the job performance video, shown during the trial, depicted "ideal circumstances, a perfectly leveled blacktop driveway, during the daylight." He stated that his job consisted of working in the middle of the night in dark lots with gravel and uneven potholes. He testified that in a lot that was uneven, one had very little room to maneuver and one would have to position the conversion gear manually. He further testified that he would have difficulty pulling himself up into the truck using his right hand, as depicted in the video. He testified that he was told specifically by Jim Keller, an agent of Respondent's, that they would not hire him back after he received permanent restrictions from Dr. Romeo; as he is not physically able to perform the job as he had performed it in 2007 and 2009. *See,* Tr. Pgs. 384-409 & RX5.

CONCLUSIONS OF LAW

F. Was Petitioner's condition resulting from the first accident causally related to the injury?

Doctor Corcoran's notes confirm a causal connection for the 2007 accident, and there is no medical evidence disputing that conclusion. Based upon the testimony and evidence of record, the Arbitrator finds that Petitioner sustained a work related injury on December 1, 2007, and that his condition of ill being and all treatment recited above, was a result of that work accident.

Is Petitioner's current condition of ill-being causally related to the injury?

Although Respondent disputes causation, Respondent has presented no evidence calling causation into question. There is a clear causal connection based not only on the facts of the case but Respondent's own IME examiner, Dr. Vitello. The opinion of Dr. Mash related to petitioner's current abilities, not causation. Dr. Romeo noted that the new MRI that was performed on May 22, 2009, revealed a full-thickness tear of the supraspinatus tendon, which was different from his previous MRI. Based upon the petitioner's release to work before the 2009 accident with permanent restrictions, the traumatic accident he suffered at work on May 8, 2009; and the subsequent new findings on diagnostic testing, the Arbitrator finds a causal connection between his subsequent condition of ill being, need for treatment and the new work accident.

In regards to Petitioner's current condition of ill-being, the Arbitrator finds that the petitioner's testimony, that he aggravated his shoulder condition on the over-the-road trip he took to Louisiana on behalf of Havner Enterprises, in August of 2011, should be noted; and that he took an additional over-the road-trip in October. While there apparently was no intervening accident, obviously, neither trip was helpful in the recovery of Petitioner right shoulder condition and should be taken into account when determining the nature and extent of Petitioner's injuries. The Arbitrator finds that the petitioner's current condition of ill-being is causally related to the May 8, 2009 accident.

J. Were the medical services provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary services?

The Arbitrator finds that the respondent is liable under Section 8(a) for all medical bills incurred as a result of the accident of December 1, 2007, based upon the evidence in the record. According to evidence presented by Respondent, these bills have been paid and Respondent shall receive credit for said payments. The Arbitrator also finds that the respondent is liable under Section 8(a) for the medical bills incurred for the accident of May 8, 2009; as stated in Petitioner's exhibit 14, which is attached to AX2; i.e. Midwest Orthopedic at Rush, with a balance in the amount of $1,903.65 and Rush Oak Park Hospital, with a balance in the amount of $15,779.83. The Arbitrator adopts Drs. Romeo and Vitello's opinions and further finds, based upon the treatment records, that all treatment was reasonable and necessary to cure petitioner of his condition of ill being. The Arbitrator notes that all of the medical services for this second accident were tendered prior to the petitioner's two trips for Havner. The respondent confirms payment to Midwest Orthopedics, leaving a $1,903.65 balance and a payment to Rush Oak Park Hospital in the amount of $13,771.89. The respondent shall receive a credit for all medical expenses paid and shall pay the remaining balance of these expenses, if any.

K. What temporary total benefits are in dispute?

The parties disagree on the dates for which TTD was payable for the December 1, 2007 accident. Having heard the testimony and reviewed the evidence, the Arbitrator finds Petitioner's request of TTD is consistent with the record of the periods of time he was kept off work, in this matter. *See,* PXs 2-12. The petitioner testified specifically to those dates he was off work and the two dates on which he returned to work in a light duty capacity for Respondent. *See*, Tr. Pg. 57. Respondent shall pay Petitioner temporary total disability benefits of $693.98/week for 53 4/7 weeks, commencing December 7, 2007 through December 15, 2008, as provided in Section 8(b) of the Act.

A review of the medical records of the second accident indicates that Petitioner was kept off work or given restrictions that would prevent the full performance of his job from May 12,

2009 through May 25, 2010; when he was found to have reached MMI and given permanent restrictions by Dr. Romeo. During that time, he testified to working light duty for Respondent on May 27, 2009 and July 4, 2009. *See,* Tr.58.

Petitioner testified that the two trips previously discussed, were the only trips made for Havner Enterprises between his dates of accident and the time of trial. *See, Tr.* at 75-76; 187. Petitioner testified he never contacted Mr. Havner in order to request additional employment opportunities. However, Mr. Havner testified Petitioner called him on more than one occasion, subsequent to the trips to Louisiana and the East Coast, requesting additional work from Havner Enterprises. *Id.* at 197. Mr. Havner testified he could not offer claimant additional trips because none were available. *Id.* at 197. Petitioner testified that after he was released to return to work with restrictions, he advised the respondent of his release and was asked what his restrictions were and upon relaying them to a Mr. Jim Keller, on or about May 25, 2010, he was told that the company could not take him back because his physical condition did not meet the job description. *See,* Tr. pgs. 407-8. Petitioner testified that the respondent did not offer him assistance in finding other work. *Id.* at 59, therefore he performed a job search on his own. Based upon the medical records and testimony in this matter, the Arbitrator orders that Respondent shall pay Petitioner temporary total disability benefits of $841.77/week for 54 2/7 weeks, commencing May 12, 2009 through May 25, 2010, as provided in Section 8(b) of the Act.

Maintenance

Pursuant to 50 Illinois Administrative Code, Chapter II Section 7110.10, (the "Code") the employer, or its representative has the burden to consult with the injured worker and his representative; and craft a written assessment of the course of medical care and if appropriate, rehabilitation required to return the injured worker to employment when 1) (s)he is unable to resume the regular duties in which (s)he was engage in at the time of the injury or 2) when the period of total incapacitation for work exceeds 120 continuous days; which ever comes first. The injured worker may also initiate and complete this process. There has not been presented, by a preponderance of the evidence that neither party pursued this process. Petitioner testified that he met with David Patsavas, a certified

vocational rehabilitation consultant, on August 13, 2010, at the request of his counsel. Petitioner was declared to have reached MMI on May 26, 2010 and from that time to the date of trial, on August 27, 2012, Petitioner has claimed to be unable to find work that exists in a stable labor market, despite a diligent search. Although a vocational expert, David Patsavas, was hired by Petitioner and testified that Mr. Fretts is currently capable of earning from $10 to $15 per hour, if he were able to find stable work; and he further opined that Mr. Fretts is a candidate for vocational rehabilitation services; no such services were established pursuant to the Code. *See,* PX16. There was no testimony or evidence presented that Petitioner worked with this counselor in instituting the process of vocational rehabilitation and that there was the authorization and implementation of a plan to return the petitioner to gainful employment, pursuant to the Code. Neither was there evidence presented of a self-directed search. The Arbitrator has not been presented with any evidence of a search, diligent or not; and as Petitioner is claiming a period of maintenance for 117 6/7 weeks, the importance of presenting evidence of such a search is paramount. Therefore, Petitioner has not been proven, by a preponderance of the evidence, that he participated in a diligent job search and no maintenance benefits or wage differential benefits, are awarded, pursuant to the Act.

L. What is the nature and extent of the injury?

The Arbitrator takes notice that the petitioner testified that the twenty (20) hour trip to Louisiana, and that is presumably one-way, aggravated his right shoulder condition. Then the petitioner took a second trip to the East Coast, delivering lawn mowers at various locations. As the petitioner claims that he cannot return to work for the respondent because of the condition of his shoulder, one can only surmise that the second trip, while putting funds in his pocket, also did not help to improve the condition of his shoulder and in fact may have exacerbated it. Prior to these trips, Petitioner sustained an injury to his right shoulder; and his medical examinations noted a right shoulder Bankart lesion; and grades 3 and 4 chondromalacia throughout both the humerus and glenoid; as well as undersurface tearing of the rotator cuff; dense thickened hypertrophic bursal tissue; as well as acromioclavicular arthropathy which was end-stage. He underwent surgery by Dr. Corcoran, who performed a right shoulder arthroscopy, chondroplasty of glenoid,

chondroplasty of humerus, arthroscopic Bankart repair, debridement of undersurface rotator cuff tear, subacromial decompression consistent of CA ligament excision, and an acromioplasty with arthroscopic distal clavicle re-section. Therefore, the Arbitrator finds that the nature and extent of petitioner's injuries, resulting from these two accidents to be 25% of the right arm or 12.65% loss of the person as a whole and awards 63.25 weeks of permanent partial disability.

M. Should penalties or fees be imposed upon Respondent?

Petitioner has filed a petition for penalties and attorneys' fees under §19(k), §19(l) and §16 of the Act. The Arbitrator declines to award penalties or fees in this matter. Respondent's conduct does not rise to the level of vexatious and unreasonable or actions taken in bad faith.

N. Is Respondent due a credit?

Respondent alleges a credit of $98,158.08 in temporary total disability and $7,045.68 for temporary partial disability, as well as $10,512.60 in permanent partial disability advances; for a total of $115, 716.36. Respondent's exhibit 3 shows payments from May 21, 2009 through December 28, 2011 totaling this amount paid as temporary total disability, temporary partial disability, and permanent partial disability advances. The Arbitrator awards this total amount of $115,716.36, as delineated by Respondent.

O. In regards to the issue of workers' compensation fraud

Two questions arise concerning the work Petitioner performed for Mr. Havner. First, would it affect Petitioner's right to temporary total disability for those days he work for Mr. Havner and second, Respondent alleges that the trip in October of 2011 constitutes workers' compensation fraud in that Petitioner received temporary total disability while also collecting a salary from a different employer. The resolution of both issues turns on an examination of the case law.

In keeping with the remedial nature of the Workers' Compensation Act and relevant case law, a claimant's earning of occasional wages does not preclude a payment of TTD. This is consistent with the law in several cases indicating that an employee does not have to be reduced to a state of total physical and mental incapacity before TTD can be awarded.

In *J. M. Jones Co. v. Industrial Commission*, 71 Ill.2d 368, 375 N.E.2d 1306, 17 Ill. Dec. 22 (1978), the Supreme Court held that the fact that the claimant was capable of driving as a school bus operator for approximately one hour in the morning and one hour in the afternoon did not preclude awarding TTD. "For the purposes of section 8(f) [section 19(b)], a person is totally disabled when he cannot perform any services except those for which no reasonably stable labor market exists." 71 Ill. 2d 353, 361-62, quoted with approval in *Zenith v. Industrial Commission*, 91 Ill.2d 278 (1982). In *Zenith*, the Supreme Court noted that the fact that the claimant occasionally sold hot dogs from a truck for a few hours per day did not bar him from TTD entitlement. The *Zenith* court also addressed whether this activity amounted to self-employment, finding that it did not.

In *Mechanical Devices v. Industrial Commission*, 344 Ill.App.3d 752, 800 N.E.2d 819, 279 Il 1. Dec. 531 (4th Dist. 2003), the appellate court again found TTD entitlement when the claimant earned occasional wages. Consistent with the court's findings in *J. M. Jones* and *Zenith*, the *Mechanical Devices* court found that a machinist who suffered an arm and back injury and returned to work as a bus driver, averaging 10 to 15 hours per week, was still disabled. The claimant's treatment was ongoing and his condition had not stabilized; therefore, the claimant was entitled to TTD benefits.

In the subject case, the entirety of Petitioner's work for Mr. Havner, during the period of time he was also receiving TTD benefits, was a few days. It is debatable whether or not this work constituted a reasonably stable labor market in that Petitioner testified that he was unable to obtain other work. Because the few days of work driving a flat-bed and pick-up truck did not establish a stable labor market and because Petitioner continued to have restrictions from his doctor, his entitlement to TTD for that period was not interrupted by the work he did for Mr. Havner in August of 2011. Likewise, the days worked light duty for Respondent did not constitute a light duty accommodation.

SECTION 25.5 OF THE ACT STATES IN PERTINENT PART:

(a) It is unlawful for any person....or entity to:
(1) Intentionally present or cause to be presented any false or fraudulent claim for

the payment of any workers' compensation benefit.
(2) Intentionally make or caused to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any worker's compensation benefit.
(3) Intentionally make or caused to be made any false or fraudulent statements with regard to entitlement to workers' compensation benefits with the intent to prevent an injures worker from making a legitimate claim for workers' compensation benefits.

For the purposes of paragraphs (2), (3), (5), (6), (7), and (9), the term "statement" includes any writing, notice, proof of injury, bill for services, hospital or doctor records and reports, or X-ray and test results.

Respondent failed to show any statement by Petitioner that was both intentional and fraudulent regarding his working for Havner Enterprises while collecting TTD. If there was a question of Petitioner's entitlement to TTD during the days that he worked for Mr. Havner; there is a lack of evidence that he lied about this work. According to case law, Petitioner could collect TTD during the limited time that he worked for Mr. Havner. In addition, the Arbitrator notes the distinction between the trucks Petitioner drove for Havner and the trucks driven for Respondent, i.e. a flat-bed and pick-up truck versus double trailers which have to be hooked to a cab. Respondent has not proven by a preponderance of the evidence, that the petitioner committed a fraudulent act.

Lastly, Respondent attempted to admit, over Petitioner's objection, a report and deposition testimony of Ms. Mary Szczepanski. She is not a certified rehabilitation counselor. She testified that she is a certified case manager. She does not possess an appropriate certification, pursuant to the Act, that designates her as qualified to render opinions relating to vocational rehabilitation. Therefore, the Arbitrator did not admit Respondent's exhibits 11 and 12.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Kao,
Petitioner,
vs.

14IWCC0040
NO: 06 WC 6270

Insight Enterprises,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent partial disability, penalties and fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 14, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $58,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2014
KWL/vf
O-12/17/13
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0040

KAO, JAMES
Employee/Petitioner

Case# 06WC006270

INSIGHT ENTERPRISES
Employer/Respondent

On 1/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
100 W MONROE ST 4TH FL
CHICAGO, IL 60603

1109 GAROFALO SCHREIBER HART & STORM
DAN GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0040

James Kao
Employee/Petitioner

v.

Insight Enterprises
Employer/Respondent

Case # 06 WC 006270

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 27, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0040

FINDINGS

On **January 26, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**21,657.75**; the average weekly wage was $**434.77**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $260.86/week for 225 weeks, because the injuries sustained caused the45% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner's claim for additional TTD benefits is denied.

Petitioner's claim for Penalties and Attorneys fees pursuant to §19(k), §19(l), and §16 is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

01-14-13
Date

JAN 14 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Kao,	)	
	)	14IWCC0040
PETITIONER,	)	
	)	
vs.	)	NO: 06 WC 6270
	)	
Insight Enterprises,	)	
	)	
RESPONDENT.	)	

MEMORANDUM OF DECISION

This MEMORANDUM OF DECISION is attached to the IWCC ARBITRATION DECISION and is made a part thereof as though fully set forth therein. The issues in dispute at the November 27, 2012 hearing were as follows:

F. Is the Petitioner's current condition of ill-being causally related to the injury?

K. Is the Respondent liable for temporary total disability benefits to the Petitioner?

L. Nature and Extent of the Petitioner's Injuries.

M. Should penalties or fees be imposed upon the Respondent?

I. FINDINGS OF FACT

A. ACCIDENT:

The Petitioner was employed by Insight Enterprises as a picker/packer. His duties included filling orders, which involved him using an electronic hand-held device to identify orders, locate various items on shelves throughout the warehouse, placing those items in boxes, and then shipping the boxes containing the items. The Petitioner testified that the boxes weighed up to 50 to 75 pounds. On January 26, 2006, the Petitioner sustained injuries to his neck, and low back, when a pallet fell from a shelf approximately 40 feet above his head, striking him in the head and knocking him unconscious.

B. MEDICAL CARE:

Following the accident in question, the Petitioner was taken to Central DuPage Hospital wherein he reported a consistent history of injury. A CT of his head was obtained that demonstrated scalp swelling and contusions. X-rays taken of the cervical spine revealed normal alignment, but bone spurs at C5-6 and C6-7. X-rays taken of the thoracic spine were normal. X-rays taken of the lumbar spine suggested a possible fracture at the L2 vertebral body. The petitioner was inpatient at Central DuPage Hospital for approximately eight days.

After the Petitioner was discharged from Central DuPage Hospital, he was transported to Marian Joy Rehabilitation Hospital on February 16, 2006, and he was inpatient at Marian Joy through February 21, 2006.

After being discharged from Marian Joy, the Petitioner was examined by Dr. Trelka on March 9, 2006, relating to his neck and back pain. Dr. Trelka recommended the Petitioner secure an EMG/NCV of the upper extremities. On March 10, 2006, the Petitioner underwent an EMG that was essentially found to be normal.

On March 13, 2006, the Petitioner was examined by Dr. Levin reporting neck pain, bilateral shoulder tingling and tightness, and dizziness at times, as well as back pain. Dr. Levin opined that the Petitioner had suffered a L2 compression fracture, and recommended MRI's of the cervical and lumbar spine.

On March 21, 2006, the Petitioner underwent MRI's of the lumbar and cervical spine. The MRI of the lumbar spine revealed a compression fracture at the L2 vertebral body. It also documented degenerative changes at the L3-4 disc, and degenerative changes at L4-5 and L5-S1 without disc herniations noted.

With respect to the cervical spine, the MRI revealed a broad-based central disc protrusion at C6-7, and some bulges at C4-5 and C5-6.

On April 27, 2006, the Petitioner came under the care of Dr. Lin. Dr. Lin referred the Petitioner to Dr. Citow for evaluation and treatment.

On May 10, 2006, the Petitioner was examined by Dr. Citow. Dr. Citow diagnosed the Petitioner with a L2 fracture, and opined that vertebroplasty may be an option.

On June 26, 2006, the Petitioner was examined by Dr. Patzik on a referral basis from Dr. Citow. Dr. Patzik recommended the Petitioner undergo a vertebroplasty, and the same was scheduled for July 6, 2006.

On July 6, 2006, the Petitioner underwent a successful vertebroplasty. It revealed a traumatic compression fracture, low back pain, and noted failure of conservative treatment.

On July 21, 2006, the Petitioner followed up with Dr. Patzik. Dr. Patzik noted the Petitioner was doing quite well following the surgery, that his low back pain had completely resolved, and that his range of motion activity level had increased significantly. Dr. Patzik discharged the Petitioner from care at that time, and noted he was to follow up on an as needed basis. The Petitioner was not provided with any work restrictions at that time.

On September 11, 2006, the Petitioner secured a script for physical therapy from Dr. Citow. The medical records do not document an examination on that date.

On October 6, 2006, the Petitioner followed up with Dr. Citow reporting a two-month history of bothersome neck pain extending into the head. He recommended a repeat MRI of the cervical spine, which was performed on October 10, 2006. The MRI revealed significant disc protrusions touching the spinal cord and narrowing the neural foramina from C3 through C7.

The Petitioner continued under the care of Dr. Citow, and participated in a course of physical therapy and injections.

On March 21, 2007, the Petitioner underwent a functional capacity evaluation at WCS at the direction of Dr. Citow. The FCE indicated that the Petitioner was functioning at the medium to heavy physical demand level.

Following the functional capacity evaluation, the Petitioner did not return to work, and instead continued to receive epidural injections at the direction of Dr. Marquardt, and also continued to treat with Dr. Citow. At no time during this period of time was the petitioner authorized off work by either Dr. Marquardt, or Dr. Citow.

On August 22, 2008, the Petitioner followed up with Dr. Citow. Dr. Citow indicated that Petitioner was able to return to work full duty.

On December 23, 2008, the Petitioner underwent an independent medical examination at the direction of petitioner's attorney with Dr. Blonsky. Dr. Blonsky opined that the Petitioner was totally disabled at that time, as was determined by Social Security. He did not believe the Petitioner was capable of returning to work, or any activities that would require the Petitioner's neck to be in a position other than neutral. Dr. Blonsky did note that he did not have all the records, including the functional capacity evaluation.

On February 20, 2009, the Petitioner followed up with Dr. Citow again. Dr. Citow recommended additional physical therapy, and additional injections.

On September 18, 2009, the Petitioner underwent a repeat MRI of the cervical spine. The MRI revealed worsening of cervical spondylosis, most prominent at the C5-6 level.

Following the MRI, the Petitioner continued under the care of Dr. Citow, and underwent another series of cervical epidural injections.

On February 22, 2010, the Petitioner underwent an anterior cervical discectomy, and fusion from C4 through C7. The postoperative diagnosis was C4-6 spondylosis and disc herniation with cord compression. Surgery was performed by Dr. Citow.

Following surgery, the Petitioner continued under the care of Dr. Citow. On March 19, 2010, Dr. Citow authored a report to Dr. Lin wherein he indicated that the petitioner could attempt to return to normal work three weeks from that date.

Subsequently, the Petitioner followed up with Dr. Citow on July 28, 2010. The Petitioner reported occipital neck pain without radicular symptoms. He noted that he had not returned to work. Dr. Citow recommended additional physical therapy followed by work conditioning, which would hopefully allow him to return to work. The Petitioner participated in physical therapy and work conditioning at the direction of Dr. Citow through October of 2010.

On September 14, 2010, the Petitioner was seen at The Geneva Pain Clinic by Dr. Lu on a referral basis from Dr. Lin, complaining of upper neck and back pain. Dr. Lu diagnosed the Petitioner with a possible suboccipital ligament injury to his neck, and discogenic low back pain. He recommended trigger point injections at that time.

On October 13, 2010, the Petitioner underwent an independent medical examination with Dr. Bauer. Dr. Bauer opined the Petitioner should be able to return to work, as delineated pursuant to a functional capacity evaluation. Dr. Bauer further indicated that the Petitioner could have returned to work in March based upon Dr. Citow's March 19, 2010 correspondence, and further opined the Petitioner was capable of returning to work at that time. Dr. Bauer opined the Petitioner had reached maximum medical improvement.

On October 28, 2010, the Petitioner underwent a functional capacity evaluation at AthletiCo. It was noted the Petitioner gave a full effort, and performed at the medium physical demand level with some components of the heavy physical demand level throughout the evaluation. The therapist opined that, based upon the employer's job description, that the physical requirements of the job would be rated at the medium physical demand level. Therefore, the Petitioner performed at the physical demand level required to perform his job at

the time of the functional capacity evaluation. If he returned to work, it was recommended that he would be given a modified schedule with breaks in order to transition the Petitioner into full time work.

On November 12, 2010, the Petitioner received a cervical epidural injection with Dr. Lu. The Petitioner was not provided with any work restrictions on that date.

On November 19, 2010, the Petitioner was last seen by Dr. Citow. Dr. Citow opined the Petitioner was able to return to work full duty as of November 22, 2010, pursuant to the functional capacity evaluation, which allowed work at the medium level.

On November 22, 2010, the Petitioner secured an off work slip from Dr. Lu. There is no corresponding medical record accompanying the off work slip.

On December 3, 2010, the Petitioner secured a referral for epidural injections from Dr. Citow. The Petitioner admitted at trial that he did not see Dr. Citow that day, but merely saw his office staff, and requested the same. On December 16, 2010, the Petitioner received an off work slip from Dr. Citow's office indicating that he was unable to return to work pending his epidural injections. The Petitioner again admitted that he did not see Dr. Citow on this date, and merely secured a disability slip from Dr. Citow's office staff.

On January 3, 2011, the Petitioner secured a disability slip from Dr. Lu indicating that he was only able to work three hours per day. There was no indication as to whether this was a permanent restriction, or a temporary restriction. There is no documentation that the Petitioner was actually seen by Dr. Lu on this date. The Petitioner admitted at trial that he did not seek treatment with Dr. Lu again after that time, as Dr. Lu became ill and stopped treating patients.

On February 10, 2011, Dr. Bauer authored an addendum to his independent medical examination. In his addendum, he noted that he reviewed recent documents, including the functional capacity evaluation and the job analysis. Dr. Bauer opined that the Petitioner was able to return to work full duty without restrictions in his position as a picker/packer for Insight Enterprises.

Subsequently, the petitioner came under the care of Lake County Millennium Pain Center. He received his first of a series of injections on February 14, 2011, and received injections at the direction of Lake County Millennium Pain Center through May of 2012.

On October 5, 2011, Dr. Citow authored a report to petitioner's attorney regarding this matter. Dr. Citow reviewed the Petitioner's medical records in

their entirety. Dr. Citow noted that he last examined the Petitioner on November 19, 2010, and at that time it was his opinion that the Petitioner was able to return to work at the level delineated in the functional capacity evaluation. In terms of future medical care, Dr. Citow noted that the Petitioner would require injections and nerve blocks as needed to control his chronic pain related to his situation. Dr. Citow related the need for injections to the accident in question.

On February 15, 2012, Dr. Citow authored another letter to petitioner's attorney regarding this matter. Dr. Citow opined that the petitioner's need for nerve blocks and injections was related to the work injury in question. Dr. Citow did not provide any additional work restrictions at that time.

C. TESTIMONY

1. Testimony of Petitioner:

The Petitioner testified that he has never returned to gainful employment since the January 26, 2006 accident in question. He admitted that he had been released to return to work following the vertebroplasty on July 6, 2006, and did not return to work because he simply thought he could not perform the job. He further admitted that, notwithstanding the fact that Dr. Citow had released him to return to work on a number of occasions, that he did not return to work simply because he did not personally believe that he could perform the job. When questioned why he never attempted to return to work following the March 21, 2007 functional capacity evaluation, the Petitioner again indicated that, although the therapist that performed the functional capacity evaluation indicated that he had met the physical demands to do his job, that he simply did not think he could do the job. The Petitioner reiterated his position with respect to his lack of any effort to return to work following his cervical fusion in 2010, and after the October 26, 2010 functional capacity evaluation at AthletiCo. Instead, the Petitioner is now attempting to rely upon the restrictions as outlined by Dr. Lu on January 5, 2011, which restricted him to three hours of work only.

In terms of his complaints, the Petitioner testified that he was only able to stand for approximately one hour, drive a car for two hours, and sit for approximately one hour. The Petitioner admitted that these were his self-imposed limitations, and that neither any of his treating physicians, nor the examining physician, has provided him with these restrictions.

With respect to the job video, the Petitioner testified that the same was inaccurate because it did not document all the different types of products that they were required to lift, and he also was of the opinion that it did not document the size of some of the products. The Petitioner indicated that some of the

products weighed between 50 and 75 pounds, which he did not feel were properly documented in the video.

2. *Deposition Testimony of Dr. Blonsky*

Dr. Blonsky testified via a deposition on June 9, 2009. He opined that the Petitioner was able to return to work on a sedentary basis. (R. 26) However, Dr. Blonsky admitted that he had not reviewed the March 21, 2007 functional capacity evaluation. (Px. 22, p. 34) He further indicated that he had not been provided with the current medical records from Dr. Citow, which released the Petitioner to return to work full duty. (Px. 22, p. 33) In terms of his credentials, Dr. Blonsky testified that he was board certified in neurology and pain management, but that he was not a surgeon, and that the only surgery that he had ever participated in was when he was an intern. (Px. 22, p. 38

3. *Deposition Testimony of Dr. Citow*

Dr. Citow testified via a deposition on January 9, 2009. Dr. Citow noted that he began treating the Petitioner on May 10, 2006 due to his cervical and lumbar complaints. Dr. Citow indicated that the Petitioner could require a cervical fusion in the future, but did not recommend surgery at that time. With respect to the Petitioner's ability to return to work, Dr. Citow indicated that as of the date of the deposition, that he had not provided the Petitioner with any work restrictions. He further testified that when he last examined the Petitioner on August 22, 2008, that he had again recommended that he return to work full duty. (Px. 23, p. 19)

4. *Testimony of Joseph Belmonte*

Mr. Belmonte, who is a certified vocational counselor, testified that he had been retained by petitioner's attorney to render an opinion regarding that Petitioner's ability to secure employment in the open labor market. Mr. Belmonte provided two different opinions. If Dr. Lu's restrictions of January 3, 2011 were controlling, which limited the Petitioner to 3 hours of work per day, then it was his opinion that the Petitioner was not a candidate for vocational rehabilitation pursuant to *National Tea*, that a stable labor market did not exist for the Petitioner, and that he was permanently and totally disabled from gainful employment. If the restrictions from Dr. Citow on November 19, 2010, which relied upon the October 28, 2010 functional capacity evaluation finding that the Petitioner was able to return to work in the medium to heavy physical demand category of work, were controlling, then it was his opinion that the Petitioner would be capable of securing gainful employment paying in the range of $11.00 per hour.

In terms of the Petitioner's former job as a picker/packer for the Respondent, Mr. Belmonte testified that he reviewed the job video, and rated the job requirements to be in the light to medium category of work. Mr. Belmonte did not provide an opinion regarding whether the Petitioner was able to return to work to that job.

5. *Testimony of Carlos Alvarez*

Mr. Alvarez testified that both the job description and job video were accurate depictions of the Petitioner's job requirements of a picker/packer position. He further testified that, at most, the boxes that the Petitioner would have been required to maneuver weighed 60 pounds, and that even then, if the box was too heavy, the employees lifted boxes together so as to avoid injury.

II. CONCLUSIONS OF LAW

The Arbitrator notes that the main issues in this case involve, whether the Petitioner's condition of ill-being is causally related to the accident in question, whether the Petitioner is entitled to additional TTD benefits, the nature and extent of the Petitioner's injuries, and whether penalties and attorneys fees are warranted.

1. Law

It is axiomatic that the Petitioner bears the burden of establishing, by a preponderance of credible evidence, all of the elements of his claim. *Illinois Institute of Technology vs. Industrial Commission,* 68 Ill. 2d 236 (1977). The requirement that the Petitioner prove by "preponderance of the evidence" all elements of his claim, means that he must present evidence which is more credible and convincing to the mind; and, when viewed as a whole establishes the fact sought to be proved as more probable than not. *In Re: K.O.,* 336 Ill. App. 3d 98 (2002). It is the duty of the arbitrator to view the evidence in it's entirety and determine, objectively and reasonably, whether witness testimony is credible, that is, "worthy of belief," based on the totality of the evidence. *Thorson v. Carlson Roofing Company,* 01 I.I.C. 0251.

Credibility is dependent upon corroboration, not in isolation on subjective intangibles such as how a witness looked or sounded. In order to properly evaluate credibility, it is necessary to consider five classic tests to the evidence: (1) witness' demeanor, (2) interest or motivation of the witness, (3) probability or improbability of the witness' version, (4) internal inconsistencies in the witness' testimony and conduct and (5) external inconsistencies when the witness' testimony is compared to other evidence, both direct and circumstantial. These sound, logical, reasonable principles are consistent with the principle of law that

uncorroborated testimony will support an award for benefits only if a consideration of all the facts and circumstances supports that decision. *Thorson v. Carlson Roofing Company,* 01 I.I.C. 0251, citing *Gano Electric Contracting v. Industrial Commission* (1994), 260 Ill. App.3d 92; *Gallantine v. Industrial Commission,* 147 Ill. Dec. 353; *Caterpillar v. Industrial Commission,* 73 Ill. 2d 311.

In support of the Arbitrator's Decision relating to whether the Petitioner's present condition of ill-being is causally related to the alleged work injury, the Arbitrator finds the following facts:

The parties stipulated that the Petitioner sustained injuries to his low back and neck as a result of the accident in question. As such, the first issue in this case is whether the Petitioner's condition of ill-being, if any, in his low back and neck is causally related to the accident in question. In terms of treatment, the records indicate that the Petitioner has not treated since May of 2012. His treatment over the last 2 years has consisted almost entirely of various injections to his low back and neck. In support of his contention that his condition of ill-being is causally related to the accident in question, the Petitioner offered his own testimony, as well as the opinion of his neurosurgeon, Dr. Citow. In rebuttal, the Respondent offered the independent medical examination report of Dr. Bauer.

In terms of the Petitioner's testimony, he testified that he has pain in his low back, and his neck, which requires periodic injections to address the same. He further testified that the injections have provided him with significant relief of his symptoms, but wear off with time. In terms of other injuries, the Petitioner denied any prior, or subsequent injurious to his low back or neck. No evidence was introduced by the Respondent to refute this contention.

In terms of the medical opinions regarding the issue of causal connection, Dr. Citow opined that the Petitioner's condition of ill-being, and the resulting need for the injections relates to the accident in question. Dr Bauer, the Respondent's §12 examining physician opined that the Petitioner had reached maximum medical improvement, and required no additional medical care including any additional injections or prolotherapy. However, Dr. Bauer did not address the issue of causal connection. Therefore, Dr. Citow's opinion regarding causal connection is unrebutted. As such, the Arbitrator adopts the opinion of Dr. Citow, and finds that the Petitioner's condition of ill-being in his neck and low back is causally related to the accident in question.

In support of the Arbitrator's Decision relating to the Nature and Extent of the Petitioner's Injuries, the Arbitrator finds the following facts:

The Arbitrator notes that the Petitioner is claiming that he is permanently and totally disabled. In support of this contention, he presented the testimony of Joseph Belmonte, a certified vocational counselor to testify regarding whether a stable labor market existed. The Petitioner also testified regarding his limitations as he notes them, and presented the January 3, 2011 disability slip of Dr. Lu in an attempt to establish permanent work restrictions.

With respect to the testimony of Mr. Belmonte, he testified that the issue of whether there was a stable labor market for the Petitioner depended on his restrictions. If the restrictions put in place by Dr. Lu on January 3, 2011, which restricted the Petitioner to only working 3 hours per day, were found to be the Petitioner's actual work restrictions, then it was his opinion that a stable labor market did not exist for the Petitioner and that he was permanently and totally disabled from gainful employment. However, if the restrictions from the October, 28, 2011 functional capacity evaluation were the appropriate restrictions, which allowed the Petitioner to return to work in the medium to heavy physical demand, and only recommended that the Petitioner be allowed a few extra breaks initially, then it was his opinion that there was a stable labor market for the Petitioner, and he would have been capable of earning $11.00 per hour in the open labor market. Mr. Belmonte did not provide an opinion as to whether the Petitioner was able to return to his former position with the Respondent. The Arbitrator notes that Mr. Belmonte's opinions and testimony were unrebutted by the Respondent. Given the unrebutted testimony of Mr. Belmonte, which the Arbitrator finds to be credible, regarding the existence of a stable labor market, the Arbitrator notes that the controlling facts involve the petitioner's work restrictions.

With respect to the petitioner's work restrictions, the Arbitrator notes that there are vastly different opinions. In support of the petitioner's contention that he is permanently and totally disabled, the Petitioner offered his own testimony regarding his limitations, and the January 3, 2011 disability slip from Dr. Lu. With respect to the Petitioner's limitations, he testified that he can drive a car for approximately 2 hours, can walk for a half hour to an hour, and can sit for an hour or 2 before he needs to lie down. The Petitioner admitted that these were his self-imposed limitations, and that his physicians did not provide him with these restrictions. The Arbitrator questions that veracity of the Petitioner's alleged limitations relating to his ability to sit. The trial on November 27, 2012 took 3 ½ hours to complete, and the Petitioner did not ask to lie down, stand up, or change positions. With respect to the other alleged limitations, that Arbitrator has no way to verify the same, but again notes that these were neither provided by a licensed medical provider, nor even mentioned in any of the voluminous treating records.

With respect to the findings of Dr. Lu, he indicated in his January 3, 2011 disability slip that the Petitioner was only able to work 3 hours per day. However,

the Arbitrator notes that Dr. Lu only treated the Petitioner on 2 occasions, never treated the Petitioner after January 3, 2011 because Dr. Lu stopped treating patients due to a personal health condition, and the records from Dr. Lu do not reflect that the Petitioner was even examined by him on January 3, 2011. There is also no indication in the disability slip that these restrictions were permanent, and Dr. Lu provided the petitioner with no additional restrictions whatsoever. The Arbitrator finds the disability slip from Dr. Lu to be unreliable, and therefore provides little weight to the same.

In support of the Respondent's contention that petitioner is able to return to work in either in his former position as a picker/packer, or is able to secure gainful employment in the open labor marker, the Respondent relied upon the October 28, 2010 functional capacity evaluation, the opinion of Dr. Citow, who was the Petitioner's treating neurosurgeon, and Dr. Bauer, the Respondent's Section 12 examining physician, who is also a neurosurgeon. The October 28, 2010 functional capacity evaluation indicates that the petitioner was able to return to work in the medium to heavy physical demand level. The therapist who performed the FCE opined that the petitioner was able to return to his former position with the Respondent, but recommend some extra breaks. Dr. Citow, reviewed the FCE on November 19, 2011 and opined that petitioner was able to return to work per the FCE. Although Dr. Citow's office subsequently provided petitioner with an off work slip on December 16, 2011, the Petitioner admitted at trial that he did not see Dr. Citow on that date, and that he merely secured the slip from Dr. Citow's office staff. As such, the Arbitrator provides no weight to this disability slip. Dr. Bauer also reviewed the functional capacity evaluation the detailed job description, and the job video. After reviewing all of those pieces of evidence, he opined that the Petitioner was able to return to work full duty for the Respondent. Dr. Citow subsequently authored a report to petitioner's attorney dated October 5, 2011. In that report, Dr. Citow reiterated his opinion that the Petitioner was able to return to work per the functional capacity evaluation. The Arbitrator finds the opinions of Dr. Citow and Dr. Bauer to be well reasoned, and supported by the only objective evidence admitted into trial regarding the Petitioner's functional capabilities, that being the October 28, 2010 functional capacity evaluation.

After weighing the conflicting opinions regarding the Petitioner's ability to return to work, the Arbitrator rejects the finding of Dr. Lu on January 3, 2011 limiting the Petitioner to 3 hours of work per day, and adopts the findings of Dr. Citow and Dr. Bauer who relied upon the October 28, 2010 findings that the Petitioner was able to return to work in the medium to heavy physical demand level. To rely upon a single disability slip of Dr. Lu would require this Arbitrator to speculate as to whether the 3 hour per day restriction was temporary, or permanent, and disregard the fact that the records from Dr. Lu do not reflect any type of an examination on January 3, 2011 and that he never examined the Petitioner again. Further, the Arbitrator would have to ignore the results of the

functional capacity evaluation on October 28, 2011, the opinion of Dr. Citow, and also the opinion of Dr. Bauer, who all opined that the Petitioner was able to return to work per the functional capacity evaluation. Further, notwithstanding the fact that the Petitioner continued to treat with different physicians through May of 2012, which is almost a year and a half after his treatment ended with Dr. Lu in January of 2011, the Petitioner did not introduce a single disability slip from the providers who have treated him since that period of time. Instead, the Petitioner admitted that his pain management physicians were relying on the restrictions from Dr. Citow, who has again opined that the Petitioner is able to return to work per the October 28, 2010 functional capacity evaluation. Therefore, the Arbitrator finds that the Petitioner is able to return to work at the medium to heavy physical demand level.

The next issue involves whether the Petitioner is able to return to work in his former position for the Respondent. The Petitioner testified that he is unable to perform the tasks associated with his old job. He claims that the job requires lifting up to 75 pounds. The Petitioner also claims the job video that the Respondent introduced at trial was inaccurate as it did not document the amount of walking required to perform the job, and also did not accurately depict how the jobs are assigned to the staff. The Arbitrator would note that neither Mr. Belmonte, nor any of the Petitioner's medical providers weighed in on the issue of whether he could return to work full duty for the Respondent.

In support of the Respondent's contention that the Petitioner's restrictions allow him to return to work full duty as a picker/packer, the Respondent relied upon a detailed written job description, a job video, the testimony of Carlos Alvarez, and the independent medical examination and subsequent addendum from Dr. Bauer. Mr. Alvarez testified that the detailed job description and video job analysis accurately depicted the duties and physical requirements of the picker/packer position for the Respondent. The Petitioner did not question the veracity of the written job description, and limited his inquiry into the veracity of video by only questioning the amount of walking required to perform the job, and the lifting requirements. Mr. Alvarez testified that job sometimes required lifting up to 60 pounds, but that the Respondent practiced group lifting where the employees would assist each other to lift heavy objects.

With respect to Dr. Bauer's opinion regarding the Petitioner's ability to return to work, he noted that reviewed his independent medical examination report, the October 28, 2010 functional capacity evaluation, the written job description, and the job video. After reviewing these pieces of evidence, he opined that the Petitioner was able to return to work full duty. The Arbitrator would note that Dr. Bauer is the only physician who provided any type of an opinion regarding the Petitioner's ability to return to work in his former position. Dr. Bauer was also the only physician who reviewed a written job analysis and a job video. As such, the Arbitrator finds Dr. Bauer's findings to be persuasive.

The final piece of evidence relating to this issue is the Petitioner's efforts to return to work. The Petitioner admitted that he never returned to work for the Respondent. He further admitted that since his accident in 2006, that Dr. Citow had released him to return to work full duty on numerous occasions, and that he still made no attempt to return to work in any capacity. Moreover, the Petitioner admitted that he made no attempt to return to work after being discharged from care by Dr. Citow on November 19, 2010, which was after he completed the final functional capacity evaluation. The Arbitrator finds the Petitioner's refusal to even make an attempt to return to work troubling at best.

After considering all of the evidence relating to the Petitioner's functional capabilities, and the requirements of his former position with the Respondent, the Arbitrator finds that the Petitioner was able to return to work full duty as a picker/packer for the insured. The Arbitrator further finds that the Petitioner sustained a 45% industrial loss of use of the man as a whole pursuant to §8(d)(2) of the Act.

K. TEMPORARY TOTAL DISABILITY BENEFITS

In support of the Arbitrator's, Decision as to whether the Respondent is liable for the temporary total disability benefits claimed by the Petitioner, the Arbitrator finds the following facts:

The parties stipulated that the Respondent paid TTD benefits from January 27, 2006 through July 22, 2006; February 22, 2010 through April 9, 2010; and from July 28, 2010 through November 23, 2010. The Petitioner claims that he is entitled to TTD benefits from January 27, 2006 through November 27, 2012, the date of trial. These claims result in 3 distinct periods of TTD benefits in dispute. The periods in dispute are: July 23, 2006 through February 21, 2010; April 10, 2010 through July 27, 2010, and November 24, 2010 through November 27, 2012.

With respect to the period from July 23, 2006 through February 21, 2010, the Arbitrator notes that the only physician that provides any kind of support to the Petitioner's contention that he is entitled to TTD benefits for this time frame was Dr. Blonsky, who was an independent medical examining physician for the Petitioner. Although Dr. Blonsky opined at the time of his deposition that the Petitioner was only capable of sedentary work, he admitted in both his report and his deposition that he did not review the March 2007 functional capacity evaluation, or any of the records from the Petitioner's treating neurosurgeon, Dr. Citow. Thus, Dr. Blonsky's opinion was not supported by any current treatment records at the time of his examination, and was not supported by the functional capacity evaluation, the findings of which are undisputed.

In support of the Respondent's decision to deny TTD benefits for this period of time, the Arbitrator would note that notwithstanding the fact that the Petitioner was treating with Dr. Citow, along with a number of other medical providers, the Petitioner did not have a single off work slip for even a portion of that period of time. Specifically, the Arbitrator would note that Dr. Patzik, who performed the Petitioner's vertebroplasty in July of 2006, discharged him from care on July 21, 2006, and did not provide Petitioner with any work restrictions. The Petitioner was examined by Dr. Citow on numerous occasions during this time and did not receive a single off work slip. Dr. Citow admitted in his deposition that he was not aware of issuing any kind of an off work slip for this period of time. In fact, Dr. Citow opined on August 22, 2008 that the Petitioner was able to work full duty. Finally, the Petitioner underwent a functional capacity evaluation on March 21, 2007, that indicated that he was able to return to work full duty. Based upon the lack of a valid off work slip from any of the Petitioner 's treating physicians from July 23, 2006 through February 21, 2010, the Arbitrator denies TTD for this time frame. Even if the Arbitrator was to adopt the finding of Dr. Blonsky, the Arbitrator notes that even Dr. Blonsky opined that Petitioner was able to return to work on a sedentary basis, and the Petitioner provided no evidence that he made any attempt to work during that period of time on a restricted basis.

With respect to the TTD in dispute from April 10, 2010 through July 27, 2010, the Arbitrator would again note that the Petitioner does not have any type of an off work slip from any of his providers for this period of time. On March 19, 2010, Dr. Citow re-examined the Petitioner and authored a report to Dr. Lin. In his report, Dr. Citow indicated that the Petitioner could attempt to return to his normal work activities three weeks from that date. Three weeks from March 19th was April 20, 2010. The Petitioner testified that he made no attempt to return to work at that time, and again did not introduce a valid off work slip until July 28, 2010. Therefore, the Arbitrator denies TTD benefits from April 10, 2010 through July 27, 2010.

With respect to the TTD in dispute from November 24, 2010 through November 27, 2012, the Arbitrator would note that the only evidence to support the Petitioner's claim for benefits for this period of time is the January 3, 2011 disability slip of Dr. Lu. As was previously noted, this slip is questionable at best. There is no evidence that the Petitioner treated with Dr. Lu that day, and no evidence that this was a permanent restriction as the Petitioner never saw Dr. Lu again.

In support of the Respondent's position that Petitioner is not entitled to TTD from November 23, 2010 through November 27, 2012, the Arbitrator would note that the Respondent is relying upon the October 28, 2010 functional capacity evaluation, the findings of Dr. Citow, and the findings of Dr. Bauer. For

the reasons discussed below, the Arbitrator finds that the Petitioner is not entitled to TTD benefits for this period of time.

The Arbitrator would begin by noting that the therapist who performed the FCE on October 28, 2010 opined that the Petitioner was able to return to work full duty. Next, the Petitioner was released to return to work per the functional capacity evaluation by Dr. Citow on November 19, 2010, but he admitted that he made no attempt to return to work at that time. Instead, he subsequently secured an off of work slip from Dr. Citow's office on December 16, 2010, but as noted previously, he admitted at trial that he did not see Dr. Citow on that date. Instead, he simply spoke with Dr. Citow's office staff, who provided him with the off work slip he requested. Third, Dr. Bauer reviewed the functional capacity evaluation along with the job description and job video, and opined that Petitioner had reached maximum medical improvement and was able to return to work full duty. Fourth, on October 5, 2011 Dr. Citow authored a narrative report wherein he reaffirmed his opinion that the Petitioner was able to return to work per the functional capacity evaluation. Finally, although it is disputed as to the Petitioner's functional capabilities, the Petitioner provided no evidence that he made any attempt to return to work for the Respondent pursuant to either the October 28, 2010 functional capacity evaluation, or the findings of Dr. Lu.

After considering all the facts germane to this period of time, the Arbitrator finds that the Petitioner is not entitled to TTD benefits. The Arbitrator adopts the findings of Dr. Citow and Dr. Bauer, and finds that Petitioner was able to return to work per the functional capacity evaluation after November 19, 2010, and reached maximum medical improvement at that time as well.

In support of the Arbitrator's Decision relating Penalties and Attorneys fee, the Arbitrator finds the following facts:

The Arbitrator adopts the findings of fact and conclusions of law as set forth in the preceding sections of this Decision as though fully set forth herein. Consequently, since this Arbitrator found that the Petitioner is not entitled to any additional TTD benefits, and that the Petitioner is not permanently and totally disabled, the Arbitrator further finds that the Respondent's decision to deny benefits was reasonable, any therefore an award of penalties and attorneys fees is not warranted.

CONCLUSION

In conclusion, the Arbitrator finds the following:

- **The Petitioner's current condition of ill-being is causally related to the January 26, 2006 accident in question;**

- **The Petitioner sustained a 45% loss of use of the man as a whole.**
- **The Petitioner's claim for additional TTD benefits is hereby denied.**
- **The Petitioner's claim for Penalties and Attorney's fees is hereby denied.**

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Honorable Kurt Carlson

01-14-13
Date